

Case Number:	CM13-0021440		
Date Assigned:	12/11/2013	Date of Injury:	09/11/2011
Decision Date:	08/25/2014	UR Denial Date:	08/14/2013
Priority:	Standard	Application Received:	09/09/2013

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to an expert reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The expert reviewer is Board Certified in Occupational Medicine, and is licensed to practice in California. He/she has been in active clinical practice for more than five years and is currently working at least 24 hours a week in active practice. The expert reviewer was selected based on his/her clinical experience, education, background, and expertise in the same or similar specialties that evaluate and/or treat the medical condition and disputed items/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

Patient is a 43 year-old female with date of injury 09/11/2011. The medical document associated with the request for authorization, a primary treating physician's progress report, dated 07/25/2013, lists subjective complaints as right wrist pain and stiffness, and right elbow and shoulder pain. Objective findings: Examination of the right wrist revealed range of motion within normal ranges. Lateral and medial epicondyles were tender to palpation bilaterally. Tinel's test was positive on the right, negative on the left. Diagnosis: status post right wrist reconstruction 2. Carpal tunnel syndrome 3. Left wrist pain 4. Left elbow pain. Patient is status post right wrist arthroscopy 01/30/2013. Patient has already been approved for 20 sessions of physical therapy to date.

IMR ISSUES, DECISIONS AND RATIONALES

The Final Determination was based on decisions for the disputed items/services set forth below:

PHYSICAL THERAPY THREE (3) TIMES A WEEK FOR FOUR (4) WEEKS ON THE BILATERAL WRIST: Upheld

Claims Administrator guideline: Decision based on MTUS Postsurgical Treatment Guidelines.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines 9792.20 - 9792.26 Page(s): 98-99.

Decision rationale: The MTUS allows for fading of treatment frequency (from up to 3 visits per week to 1 or less), plus active self-directed home Physical Medicine. Prior to full authorization, therapeutic physical therapy is authorized for trial of 6 visits over 2 weeks, with evidence of objective functional improvement prior to authorizing more treatments. The patient has already participated and 20 physical therapy visits. There is no documentation of objective functional improvement. The request for Physical Therapy is not medically necessary.