

Case Number:	CM13-0039165		
Date Assigned:	12/18/2013	Date of Injury:	01/05/2006
Decision Date:	03/11/2014	UR Denial Date:	09/23/2013
Priority:	Standard	Application Received:	10/03/2013

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Physical Medicine and Rehabilitation has a subspecialty in Neuromuscular Medicine and is licensed to practice in Maryland. 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 physician 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:

The patient with a date of birth [REDACTED] and a work injury dated 1/5/06 after she sustained a fall. The patient eventually underwent an arthroscopic synovectomy, debridement and repair of the TFCC and lunotriquetral ligament repair for instability of the right wrist on 11/21/12. Per documentation patient had 14 post op therapy visits in an office visit on 9/03/2013, the patient complained of worsening pain in the right wrist. On physical exam, there were positive Tinel's signs and Phalen's tests at the wrists bilaterally. There were positive Tinel's signs over the ulnar nerves at the elbows bilaterally. There was moderate tenderness and swelling on the dorsal right wrist. The right wrist extension measured 45 degrees and flexion was 20 degrees. At this visit the physician agrees with the Agreed Medical Evaluation recommendation for physical therapy for the right wrist. He states that this is for desensitization, stretching, strengthening and range of motion of the wrist. Additional documentation reveals patient is having pain in the neck, shoulder, arm and hand. Medical record review indicates that she has undergone procedures which include a hemocyte auto graft being done for the purposes of sealing, filling, and repairing injured tendons. She also had chemodenervation of the bilateral cervical region with botulinum toxin and chemodenervation of the bilateral extremities and trunk with Botox injection for spasm of muscles and cervical dystonia. There is also a diagnosis of thoracic outlet syndrome on an operative report from 6/20/13. On 2/22/13 patient reported she was doing well until 4 days prior when she began having increased left wrist pain. She was fitted with bilateral cock up splints. At this visit continued hand therapy 2 x week for 6 weeks was recommended. A nerve conduction study performed on 5/6/13 revealed bilateral carpal tunnel syndrome, bilateral cubital tunnel syndrome. The physician performed a median nerve block on 5/13/13 with Celestone and Marcaine on the right wrist which gave some relief. On 7/12/13 the Agreed Medical Evaluation

by the physician indicates that the patient states that the pain in her right wrist was slightly improved after this surgery. She was having persistent numbness in the hand. She was having increasing symptoms on the left which were felt to be due to overuse after her right upper extremity injury. He recommends Physical Therapy to the wrist.

IMR ISSUES, DECISIONS AND RATIONALES

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

Physical Therapy 2 x week x 6 weeks, right wrist: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 99, Postsurgical Treatment Guidelines Page(s): 22. Decision based on Non-MTUS Citation Official Disabilities Guidelines, Forearm, Wrist, and Hand

MAXIMUS guideline: Decision based on MTUS Postsurgical Treatment Guidelines Page(s): 22.

Decision rationale: Per MTUS guidelines Physical Therapy 2 x week x 6 weeks, right wrist is not medically necessary. Per documentation patient has had at least 14 sessions of PT post operatively. This exceeds guideline recommendations for her condition. There is no documentation of functional improvement. Patient should be well versed in a home exercise program. There is no evidence of extenuating circumstances which would limit patient from performing a home exercise program or needing additional right wrist therapy. Therefore, the request is not medically necessary.