

Case Number:	CM13-0056605		
Date Assigned:	12/30/2013	Date of Injury:	01/29/2013
Decision Date:	05/02/2014	UR Denial Date:	11/13/2013
Priority:	Standard	Application Received:	11/22/2013

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 Physical Medicine and Rehabilitation 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:

The patient is a 57 year old male who was injured on 01/29/2013 after being involved in a motor vehicle accident. The worker's prior treatment history has included 8 sessions of physical therapy and diagnostic studies reviewed include an X-ray of the left wrist revealing acute Nondisplaced ulnar styloid fracture of the left wrist. The MRI of the left wrist dated 04/24/2013 revealing: 1) Focal mild degenerative changes of the radiocarpal joint between the radius and adjacent scaphoid. 2) Mild degenerative changes of the STT joint. 3) Type II lunate with moderate associated degenerative changes. 4) TFCC central perforation. 5) Mild degenerative changes of the first CMC joint. 5) Mild degenerative changes of the distal radioulnar joint. X-rays of the left wrist dated 04/25/2013 reveal that the ulnar styloid is intact with styloid pins remain very tiny. However, there is new radiolucent line along the waist of the scaphoid previously unseen on previous x-rays. The orthopedic note dated 10/24/2013 documented the patient completed five of his current physical therapy sessions. He is having some discomfort when grasping. Pain is approximately 5/10. He continues to do his home exercises and was negative for worsening joint pain or arthralgias elsewhere. The objective findings on examination of the left wrist reveal some mild snuffbox tenderness to palpation and range of motion is near full with dime deficits noted with dorsiflexion and volar flexion. Upper extremity neurovascular exam is intact and distal circulation is intact with distal capillary refill less than two seconds. There was a physical therapy discharge summary dated 11/14/2013 documented the patient's constant pain is at the base of his thumb although he says it is less.

IMR ISSUES, DECISIONS AND RATIONALES

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

ADDITIONAL PHYSICAL THERAPY ONE TO TWO (1-2) TIMES A WEEK FOR FOUR (4) WEEKS FOR THE LEFT WRIST: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Section Page(s): 98-99. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Forearm, Wrist and Hand Chapter.

Decision rationale: According to the Official Disability Guidelines (ODG), physical therapy post carpal bone fracture is recommended as an early therapy without immobilization that may be sufficient for some types of non-displaced fractures. Allow for fading of treatment frequency (from up to 3 visits or more per week to 1 or less), plus active self-directed home PT. More visits may be necessary when grip strength is a problem, even if range of motion is improved. Medical treatment: 8 visits over 10 weeks. The medical records document the patient had fracture in the styloid process of the left ulna with fracture of left scaphoid bone. Recent x-ray dated 8/15/2013 revealed presence of radiolucent faint line and no evidence of AVN. The patient finished 8 sessions of physical therapy with full improvement of passive and active ROM and the strength of the left wrist. The physical therapy discharge summary dated 11/14/2013 documented the patient reports he feels he is able to perform all duties of his job. As the patient had the maximum improvement in the left wrist with full ROM and strength within the maximum number of medical treatment, the request is not medically necessary according to the guidelines. The CA MTUS guidelines state patients are instructed, and expected, to continue active therapies at home as an extension of the treatment process in order to maintain improvement levels. It is reasonable that the patient may continue a home exercise program to maintain functional improvement. Therefore the request for additional physical therapy is non-certified.

6 IONTOPHORESIS ELECTRODES: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG)

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 206. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Forearm, Wrist and Hand Chapter

Decision rationale: According to the ACOEM Guidelines, the support for iontophoresis and phonophoresis is limited. According to the Official Disability Guidelines (ODG), iontophoresis is understudy and the support is limited. As the patient showed a significant improvement with full ROM and strength of the left wrist from prior treatment. The necessity of this treatment is not met according to the guidelines. Therefore the request is non-certified.

18cc dexamethasone 1.25 per cc: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG)

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 265.

Decision rationale: According to the ACOEM Guidelines, corticosteroid injections are recommended as treatment for the tendon sheaths or for CTS in cases resistant to conservative therapy for 8 to 12 weeks. The medical records document the patient was diagnosed with fracture of carpal bone of left wrist with fracture of left styloid process of ulna. Significant healing and full ROM and strength of the left wrist were reported. In the absence of documentation of any disease in the tendons or CTS in the left wrist, the request is not medically necessary according to the guidelines. Therefore the request is non-certified.