

<b>Case Number:</b>	CM13-0059769		
<b>Date Assigned:</b>	12/30/2013	<b>Date of Injury:</b>	10/11/2012
<b>Decision Date:</b>	04/10/2014	<b>UR Denial Date:</b>	11/15/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	12/02/2013

### 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 & Rehabilitation and is licensed to practice in Texas. 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 28-year-old female who reported an injury on 10/11/2012. The injury was noted to have occurred when she reached to grab a coffee machine, which was falling, and held onto it with a lot of force, injuring her right wrist and hand. She is diagnosed with right lower back pain, right wrist volar ganglion cyst, and right wrist scaphoid cyst. The patient had surgery to remove her right wrist volar ganglion cyst on 05/20/2013. Her most recent office note provided, dated 12/13/2013, and indicates that the patient had continued pain in her right wrist and hand. Her physical exam findings were noted to include decreased swelling in the right hand and "near full" range of motion. It was noted that the patient had made significant progress with therapy; however, she still had functional deficits and would likely improve from additional therapy.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**ADDITIONAL PHYSICAL THERAPY, 3X4:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints.

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

**Decision rationale:** According to the California MTUS Guidelines, physical medicine is recommended in the treatment of unspecified myalgia and myositis at 9 to 10 visits over 8 weeks. The clinical information submitted for review indicated that the patient had made functional improvement with previous physical therapy visits; however, details regarding the patient's physical therapy, including the completed number of visits and duration of treatment were not provided in the medical record. Additionally, specific documentation including evidence of measurable objective functional gains made with previous physical therapy were not provided for review. Additionally, the patient's most recent physical examination findings failed to show evidence of measurable objective functional deficits to warrant continued physical therapy. Additionally, the request for physical therapy 3 times a week x4 weeks in addition to the patient's unspecified number of already completed physical therapy visits would exceed the guidelines' recommendations for a total of 9 to 10 visits over 8 weeks. Therefore, documentation would need to show specific exceptional factors to warrant additional physical therapy beyond the guidelines' recommendations. For these reasons, the requested service is non-certified