

Case Number:	CM13-0071379		
Date Assigned:	01/08/2014	Date of Injury:	09/30/2011
Decision Date:	04/24/2014	UR Denial Date:	12/03/2013
Priority:	Standard	Application Received:	12/27/2013

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:

The applicant is a represented [REDACTED] employee who has filed a claim for chronic wrist pain reportedly associated with an industrial injury of September 30, 2011. Thus far, the applicant has been treated with the following: Analgesic medications; attorney representations; right wrist arthroscopic TFCC repair surgery with open excision of the ulnar styloid nonunion fragment of September 5, 2013; and 12 sessions of postoperative physical therapy, per a Utilization Review Report of December 3, 2013. In said Utilization Review Report of December 3, 2013, the claims administrator denied a request for additional postoperative occupational therapy. The applicant's attorney subsequently appealed. A January 17, 2014 progress note is notable for comments that the applicant reports persistent wrist, low back, and ankle pain. The applicant exhibits a healed surgical scar about the right wrist with limited wrist range of motion noted. The wrist range of motion is described as limited, 0 to 70 degrees of flexion and extension are appreciated with 5/5 upper and lower extremity strength. The applicant exhibits a normal gait. She is asked to continue working without restrictions. In a January 28, 2014 occupational therapy note, the applicant is described as having had 12 sessions of occupation therapy through that point in time. The applicant was on Naprosyn and Norco. She had tenderness about the ulnar aspect of the forearm. Grip strength was diminished about the right hand versus the left, with grip strength range of 15 to 20 pounds about the right side versus 40 to 55 pounds about the left. Additional occupational therapy was sought.

IMR ISSUES, DECISIONS AND RATIONALES

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

**OCCUPATIONAL THERAPY (OT) TWO TIMES A WEEK FOR FOUR (4) WEEKS,
RIGHT WRIST: Overturned**

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

MAXIMUS guideline: Decision based on MTUS Postsurgical Treatment Guidelines.

Decision rationale: While this does result in extension of treatment slightly beyond the 16-session course recommended in MTUS 9792.24.3 following TFCC reconstruction surgery and slightly beyond the 10-session course recommended in MTUS 9792.24.3 for arthroscopic TFCC debridement surgery, in this case, however, the applicant has had a surgery which does not neatly fall under either guideline. The applicant, in addition to undergoing an arthroscopic debridement surgery, also underwent an open excision of an ulnar styloid nonunion fragment. The applicant did demonstrate functional improvement with the 12 prior sessions of physical therapy. She did return to regular work. However, she was described on an occupational therapy evaluation of January 28, 2014 as exhibiting diminished right hand grip strength as compared to the contralateral left hand. Additional postoperative physical therapy to ameliorate the applicant's residual wrist deficits was indicated inappropriate. Therefore, the original Utilization Review decision is overturned. The request is certified, on Independent Medical Review, given the applicant's residual postoperative deficits and functional improvement with prior treatment as evinced by the applicant's successful return to regular work. Therefore, the original Utilization Review decision is overturned. The request is certified, on Independent Medical Review.