

<b>Case Number:</b>	CM14-0119162		
<b>Date Assigned:</b>	08/06/2014	<b>Date of Injury:</b>	12/19/2013
<b>Decision Date:</b>	11/04/2014	<b>UR Denial Date:</b>	07/07/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	07/29/2014

### 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 & Ohio. 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 injured worker is a 40-year-old female who reported an injury on 12/19/2013. The mechanism of injury was a trip and fall. Diagnoses included status post left wrist arthroscopic repair of peripheral triangular fibrocartilage complex ligament tear. Past treatments included physical therapy. Pertinent diagnostic testing was not provided. Surgical history included left wrist arthroscopic repair of peripheral triangular fibrocartilage complex ligament tear on 05/27/2014. The clinical note dated 06/23/2014 indicated the injured worker complained of moderate pain in the left wrist and a burning sensation of the posterior hand. Physical exam of the left wrist revealed a well healing incision, mild swelling, limited range of motion, and distally neurovascularly intact with good hand function and sensation. Current medications were not provided. The treatment plan included occupational therapy 2 times a week for 6 weeks for the left wrist and hand. The rationale for the treatment plan was to increase range of motion. The Request for Authorization form was not provided.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Occupational Therapy 2x6 left wrist/hand:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Postsurgical Treatment Guidelines Page(s): 22.

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

**Decision rationale:** The request for occupational therapy 2 times a week for 6 weeks for the left hand and wrist is not medically necessary. The California MTUS Guidelines indicate that postsurgical physical therapy is recommended for TFCC injuries to include 10 visits over 10 weeks, with an initial course of therapy of 5 visits. It is unclear how many postsurgical therapy sessions the injured worker had completed. Additionally, the most recent clinical note dated 06/23/2014 indicated that the injured worker's left wrist was placed in a short arm cast. There is a lack of clinical documentation of functional deficits, including values for range of motion and motor strength after the cast had been removed. Additionally, 12 visits of therapy would exceed the guideline recommendation of 10 visits. Therefore, the request for occupational therapy 2 times a week for 6 weeks to the left wrist and hand is not medically necessary.