

<b>Case Number:</b>	CM14-0125808		
<b>Date Assigned:</b>	08/11/2014	<b>Date of Injury:</b>	10/04/2013
<b>Decision Date:</b>	09/18/2014	<b>UR Denial Date:</b>	07/24/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	08/07/2014

### 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 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:

There were 17 pages provided for review. There was an application for independent medical review signed on July 28, 2014. The item there was denied or modified was physical therapy times eight sessions of the left wrist in the fourth finger. There was a primary treating physician's initial report from July 1, 2014. There is intermittent aching left finger wrist and forearm pain. The date of injury was October 4, 2013. She stubbed the left ring finger on the desk and it broke but it still hurts and it turns in. Her immediate symptoms were left ring finger turning in and pain. She was placed in an aluminum finger splint and prescribed Etodolac. She was referred to a hand specialist. She returned to modified duty of no use of the left hand. She was seen by an orthopedic surgeon on October 21, 2013. The x-rays done showed a proximal phalangeal ulnar base fracture with intra-articular extension with minimal displacement. They buddy taped the finger. The EMG testing showed an incidental mild carpal tunnel syndrome of the left upper extremity. She had a cortisone injection. She was to continue with her home exercise program as of March 3, 2014. She was last seen on June 2, 2014 but she has retired. She is status post a fourth proximal phalanx fracture with minimal rotation. She also has a carpal tunnel syndrome of the left wrist. The request was for the physical therapy two times a week for four weeks to the left wrist and the fourth finger.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Physical Therapy X 8 sessions -left wrist/4th finger:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Integrated Treatment/Disability Duration Guidelines Forearm, Wrist & Hand (Acute & Chronic).

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

**Decision rationale:** The MTUS does permit physical therapy in chronic situations, noting that one should allow for fading of treatment frequency (from up to 3 visits per week to 1 or less), plus active self-directed home Physical Medicine. The conditions mentioned are Myalgia and myositis, unspecified (ICD9 729.1): 9-10 visits over 8 weeks; Neuralgia, neuritis, and radiculitis, unspecified (ICD9 729.2) 8-10 visits over 4 weeks; and Reflex sympathetic dystrophy (CRPS) (ICD9 337.2): 24 visits over 16 weeks. This claimant does not have these conditions. And, after several documented sessions of therapy, it is not clear why the patient would not be independent with self-care at this point. Also, there are especially strong caveats in the MTUS/ACOEM guidelines against over treatment in the chronic situation supporting the clinical notion that the move to independence and an active, independent home program is clinically in the best interest of the patient. This request for more skilled, monitored therapy was appropriately not medically necessary.