

<b>Case Number:</b>	CM14-0133204		
<b>Date Assigned:</b>	09/18/2014	<b>Date of Injury:</b>	03/07/2014
<b>Decision Date:</b>	10/21/2014	<b>UR Denial Date:</b>	08/08/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	08/20/2014

### 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 Orthopedic Surgery 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:

71 year old male claimant with an industrial injury dated 03/07/14. The patient is status post an open reduction internal fixation, bilateral distal radius fracture with residual radial shortening. Conservative treatments have includes occupational therapy (OT) for the bilateral wrists, physical therapy (PT) for the bilateral shoulders, and medication. Exam note 07/28/14 states that the patient returns with neck, bilateral shoulder, bilateral elbow, bilateral forearm, bilateral wrist/hand, low back and knee pain. The patient reports that the pain is leading to stiffness, numbness and tingling. The patient rates the pain a 3-8/10. The patient has increasing pain when reaching the end of the range of motion tests. The shoulders had a positive Neer's impingement test, and a positive Hawkins-Kennedy impingement test. The hands and wrists were noted to have a positive Tinel's test, along with a positive Duran's median compression test. There was increased pain in the lumbar region when completing the terminal range of motion. Additionally, there was crepitus during the range of motion of the left knee, and palpable masses of the left knee with tenderness. Treatment includes physical therapy and occupational therapy for the wrists/ shoulders.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Occupational therapy (OT) 2-3 x 6 weeks:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Page(s): 98-99, Postsurgical Treatment Guidelines.

**MAXIMUS guideline:** Decision based on MTUS Postsurgical Treatment Guidelines Page(s): 20.

**Decision rationale:** According to the CA MTUS/Post-surgical treatment guidelines, Fracture of radius/ulna, page 20, 16 visits are authorized over 8 weeks. In this case the exam note from 7/28/14 does not demonstrate how many visits have been completed thus far or what functional improvement has been demonstrated. Therefore the request for OT 2-3 x 6 weeks is not medically necessary and appropriate.

**Physical therapy (PT) 2-3 x 6 weeks, bilateral hand/wrist and bilateral shoulders:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Page(s): 98-99, Postsurgical Treatment Guidelines.

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

**Decision rationale:** CA MTUS/Chronic Pain Medical Treatment Guidelines, Physical Medicine page 98-99 recommend the following for non-surgical musculoskeletal conditions, Physical Medicine Guidelines, Allow for fading of treatment frequency (from up to 3 visits per week to 1 or less), plus active self-directed home Physical Medicine. 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. As the requested physical therapy exceeds the recommendation, the determination is not medically necessary and appropriate.