

<b>Case Number:</b>	CM14-0024854		
<b>Date Assigned:</b>	06/04/2014	<b>Date of Injury:</b>	06/18/2012
<b>Decision Date:</b>	08/05/2014	<b>UR Denial Date:</b>	02/19/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	02/27/2014

### 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 Illinois. 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 23-year-old female who reported an injury on 06/18/2012. The injury was reportedly caused by hanging heavy clothes on a rack. The injured worker reportedly sustained an injury to her left shoulder and left upper extremity. The injured worker ultimately underwent surgical intervention for the left wrist after a failure to respond to conservative therapy. The injured worker's surgical intervention was followed by postoperative physical therapy. However, the injured worker had ongoing pain complaints and functional limitations. The injured worker was evaluated for pain management on 12/16/2013. She was prescribed Lidocaine patch, Neurontin 300 mg 3 times a day, and extra strength Tylenol to assist with pain control. Physical findings included tenderness to palpation of the left wrist. The injured worker's diagnoses included left hand pain. The request was made for physical therapy, and nerve conduction velocity (NCV) of the bilateral upper extremities, an X-ray of the left wrist, and MR arthrogram of the wrist, and a functional capacity evaluation for the wrist; however, no justification for the requests was provided.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**PHYSICAL THERAPY THREE (3) TIMES A WEEK FOR FOUR (4) WEEKS FOR THE LEFT WRIST:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 2 General Approach to Initial Assessment and Documentation.

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

**Decision rationale:** MTUS Guidelines recommend physical therapy to address pain, weakness, and range of motion deficits. The clinical documentation submitted for review does indicate that the injured worker has ongoing pain complaints, however, the injured worker's treatment history includes both presurgical and postsurgical physical therapy. The guidelines recommend that injured workers be transitioned into a home exercise program to maintain improvement levels obtained during skilled physical therapy. The clinical documentation submitted for review does not indicate that the injured worker is participating in a home exercise program. Therefore, 1 to 2 visits would be appropriate to re-establish a home exercise program, and the requested 12 visits would be considered excessive. As such, the request is not medically necessary.

**NCV STUDIES OF BILATERAL UPPER EXTREMITIES:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 2 General Approach to Initial Assessment and Documentation.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 270-271.

**Decision rationale:** ACOEM Guidelines recommend electrodiagnostic studies when there is suspicion of peripheral nerve involvement. The clinical documentation submitted for review does not provide any evidence of peripheral nerve involvement. There is no decreased sensation, decreased grip strength, or significant weakness of the upper extremities to support the need for an electrodiagnostic study. Additionally, the clinical documentation submitted for review only provides left sided deficits. Therefore, the need for bilateral electrodiagnostic studies is not clearly indicated. As such, the request is not medically necessary.

**X-RAY OF LEFT WRIST:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 2 General Approach to Initial Assessment and Documentation.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 270-271.

**Decision rationale:** The requested X-ray of the left wrist is not medically necessary or appropriate. The American College of Occupational and Environmental Medicine recommends x-rays of the upper extremities when there is suspicion of fracture or red flag conditions. The clinical documentation submitted for review does not provide any evidence that the patient is suspected of having a fracture or any other type of red flag conditions that would require further imaging. Therefore, an x-ray of the left wrist would not be indicated in this clinical situation. As such, the requested x-ray of the left wrist is not medically necessary or appropriate.

## **MR ARTHROGRAM OF LEFT WRIST: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 2 General Approach to Initial Assessment and Documentation.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Forearm, Wrist and Hand Chapter, MRI's.

**Decision rationale:** Official Disability Guidelines recommend MRIs or MR arthrography for patients with chronic wrist pain that are suspected of having a soft tissue tumor or Kienbock's disease. The clinical documentation submitted for review does not clearly identify that the injured worker is at risk for developing Kienbock's disease or is suspected of having a soft tissue tumor. Therefore, the need for this type of procedure is not clearly indicated. As such, the request is not medically necessary.

## **FUNCTIONAL CAPACITY EVALUATION (FCE) FOR LEFT WRIST: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 5 Cornerstones of Disability Prevention and Management Page(s): 89-92.

**Decision rationale:** ACOEM Guidelines recommend a functional capacity evaluation when a more precise delineation of an injured worker's functional capabilities is required beyond what could be provided from a traditional physical examination. The clinical documentation submitted for review does not provide any evidence that the patient is at or near maximum medical improvement and has had multiple return to work attempts. It is noted within the documentation that the patient is working at a modified work duty level. Therefore, the need for a functional capacity evaluation beyond what can be provided from a thorough traditional examination from the treating provider is not clearly indicated. As such, the request is not medically necessary or appropriate.