

<b>Case Number:</b>	CM14-0031671		
<b>Date Assigned:</b>	06/20/2014	<b>Date of Injury:</b>	02/22/2013
<b>Decision Date:</b>	08/05/2014	<b>UR Denial Date:</b>	02/28/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	03/12/2014

### 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 and 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 49-year-old female who reported an injury on 02/22/2013. The mechanism of injury was not provided. On 02/20/2014, the injured worker presented with increasing pain and discomfort in her right upper extremity. She reported that the pain shoots up her arm and into the neck. Upon examination, there was sensation intact to light touch and tenderness to palpation diffusely about the right forearm, base of the thumb, dorsal radial aspect of the wrist, and dorsal aspect of the hand. Prior therapy included physical therapy and medications. The diagnoses were right de Quervain's tenosynovitis and right wrist and forearm tendonitis. The provider recommended physical therapy 2 times a week for 4 weeks for the right wrist. The provider's rationale was not provided. The request for authorization form was not included in the medical documents for review.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Physical Therapy 2Xweek X 4Weeks, Right Wrist:** Upheld

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

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

**Decision rationale:** The request for physical therapy 2 times a week for 4 weeks for the right wrist is not medically necessary. The California MTUS state that active therapy is based on the philosophy that therapeutic exercise and/or activity are beneficial for restoring flexibility, strength, endurance, function, range of motion, and can alleviate discomfort. Active therapy requires and internal effort by the individual to complete a specific exercise or task. Injured worker's are instructed and expected to continue active therapies at home as an extension of the treatment process in order to maintain improvement levels. The guidelines allow for up to 10 visits of physical therapy for up to 4 weeks. There was lack of documentation indicating the injured worker's prior course of physical therapy as well as the efficacy of the prior therapy. The amount of physical therapy visits that already been completed for the right wrist was not provided. Injured workers are also instructed and expected to continue active therapies at home, and there is no significant barriers to transitioning the injured worker to an independent home exercise program. As such, the request is not medically necessary.