

Case Number:	CM14-0052431		
Date Assigned:	07/07/2014	Date of Injury:	04/16/2013
Decision Date:	08/13/2014	UR Denial Date:	04/02/2014
Priority:	Standard	Application Received:	04/21/2014

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 has a subspecialty in Neuromuscular Medicine and is licensed to practice in Maryland. 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 patient is a 55 year old male with a work injury dated 4/16/13. The diagnoses include status post left wrist arthroscopy, synovectomy, open scapholunate ligament repair, TFCC debridement and chondroplasty 11/27/13. The documentation indicates that the K-wire and pins were removed 12/23/13. Per documentation post op physical therapy left hand 12 Visits certified 1/24/14. The total number of therapy certified is 20 visits. Under consideration is a request for post op physical therapy for the left hand. There is a primary treating physician (PR-2) document dated 2/13/14 that states that the patient is progressing but slower than expected. Objective findings state decreased grip and another illegible word. The treatment plan states continue therapy. An MRI of the left wrist dated 06/10/13 was positive for a fracture deformity of the scaphoid with extensive posttraumatic marrow contusion, complete TFCC tear, old ulnar styloid fracture, tendinopathy of the extensor carpi, degenerative changes of the distal radioulnar joint. The results were consistent with scaphoid fracture, a complete tear of the triangular fibrocartilage complex and old ulnar styloid fracture and degenerative changes at distal radioulnar joint.

IMR ISSUES, DECISIONS AND RATIONALES

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

Post-op physical therapy for the left hand: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints.

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

Decision rationale: The guidelines recommend up to 20 visits of therapy for this condition. The documentation indicates that the patient has been certified this amount. The documentation does not reveal findings of extenuating circumstances that would warrant continued therapy. The patient is beyond the post op period. The MTUS Chronic Pain Medical Treatment Guidelines recommend a transition to a self directed home exercise program. The patient should be well versed by now in these exercises. Furthermore the request as written does not indicate a quantity or duration of the requested therapy. The request for post-op physical therapy for the left hand is not medically necessary.