

<b>Case Number:</b>	CM14-0054973		
<b>Date Assigned:</b>	07/07/2014	<b>Date of Injury:</b>	03/05/2013
<b>Decision Date:</b>	08/22/2014	<b>UR Denial Date:</b>	04/07/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	04/24/2014

### 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 and Rehabilitation has a subspecialty Certificate in Pain Management 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:

This is a patient with a date of injury of 3/5/13. A utilization review determination dated 4/7/14 recommends non-certification of physical therapy. The patient had surgery for a Colles' fracture on 3/11/13 with 20 physical therapy visits. 3/19/14 medical report identifies left wrist/arm pain radiating into the shoulder 7-10/10. On exam, there is tenderness at the distal radius and range of motion is limited with 10 degrees each of dorsiflexion, palmar flexion, ulnar deviation, and radial deviation. Pronation is 60 degrees and supination is 0 degrees. The provider notes a need for extensive physical therapy and, if he is not much improved, possible permanent and stationary.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Physical therapy 2 times a week for 4 weeks for left wrist:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG).

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines 8 C.C.R. 9792.20 - 9792.26 MTUS (Effective July 18, 2009) Page 98-99 of 127 Physical Medicine Page(s): 98-99 of 127.

**Decision rationale:** Regarding the request for physical therapy, California MTUS cites that patients are instructed and expected to continue active therapies at home as an extension of the treatment process in order to maintain improvement levels. Within the documentation available for review, the patient underwent surgery for a fracture of the distal radius approximately one year prior to the current request. Subsequently, he underwent 20 physical therapy sessions. Currently, range of motion is significantly limited, although no distinction is made between passive and active range of motion. There is no clear rationale identifying why, with such limited range of motion despite extensive physical therapy, additional physical therapy would be expected to provide any additional functional improvement. Without any clear expectation of improvement, there is no clear indication for additional formal physical therapy. In light of the above issues, the currently requested physical therapy is not medically necessary.