

<b>Case Number:</b>	CM14-0062578		
<b>Date Assigned:</b>	07/11/2014	<b>Date of Injury:</b>	09/19/2000
<b>Decision Date:</b>	08/08/2014	<b>UR Denial Date:</b>	04/07/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	05/05/2014

### 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 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 56-year-old female who reported injury on 09/19/2000. The mechanism of injury is not submitted in the report. Due to injury, the injured worker underwent surgical procedure, including a partial wrist fusion, which was done on 11/01/2013. Progress evaluation dated 03/24/2014 noted that the injured worker complained of pain in both wrists and right thumb. She also stated she had numbness in the right hand, and pain when she moved her hand up and down. There is no measurement of pain level documented in the submitted report. Physical findings revealed that the injured worker had very limited range of motion to the right wrist. She had an extension of 10 degrees, flexion of 10 degrees. The submitted report lacked any evidence of any past diagnostic testing the injured worker underwent. The injured worker has diagnoses of bilateral wrist sprain/strain, trigger thumb to the right, and right wrist ganglion cyst. Her past medical treatment includes injections for the trigger thumb, physical therapy, electrical stimulator, ultrasound, heat/cold modalities, and medication therapy. Medications include Norco 10/325 mg #40 and baclofen compound cream. The current treatment plan is for physical therapy 2 times a week for 6 weeks. The rationale and request for authorization form were not submitted for review.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**PHYSICAL THERAPY 2X WK FOR 6 WKS:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation OFFICIAL DISABILITY GUIDELINES, 2014, FOREARM, WRIST, AND HAND:OFFICIAL DISABILITY GUIDELINES PHYSICAL/OCCUPATIONAL THERAPY GUIDELINES.

**MAXIMUS guideline:** Decision based on MTUS Postsurgical Treatment Guidelines Page(s): page(s) 19.

**Decision rationale:** The injured worker complained of right wrist and hand pain following a partial wrist fusion. The California Medical Treatment Utilization Schedule (MTUS) guidelines recommend a postsurgical treatment plan of 24 physical therapy visits over 8 weeks. There was no evidence proving that the injured worker would benefit from additional physical therapy and not a home exercise program. The submitted physical therapy reports lacked specific progress notes on the efficacy of prior physical therapy, only notes of "No change". The current progress note, dated 03/24/2014 failed to document functional deficits, motor strength and detailed range of motion. The injured worker has had 20 visits of physical therapy dated from 12/01/2013 through 03/19/2014, exceeding Guideline criteria with the MTUS. As such, the request for physical therapy 2x wk for 6 wks is not medically necessary and appropriate.