

<b>Case Number:</b>	CM14-0209398		
<b>Date Assigned:</b>	12/22/2014	<b>Date of Injury:</b>	04/20/2011
<b>Decision Date:</b>	02/18/2015	<b>UR Denial Date:</b>	12/08/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	12/12/2014

### 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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:

State(s) of Licensure: California, Hawaii

Certification(s)/Specialty: Physical Medicine & Rehabn

### 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 43 year old female with date of injury 04/20/11. The treating physician report dated 11/10/14 (17) indicates that the patient presents with pain affecting her left wrist. The physical examination findings reveal healed incisions, obvious deformity that has the wrist in a radially deviated posture, and tenderness. Prior treatment history includes left wrist arthroscopy (03/2012), ORIF distal radius (08/2013), open reduction internal fixation bone grafting of the distal radius osteotomy site along with distal ulnar resection (08/2014), postoperative therapy, and medications. The current diagnoses are: 1. Status post distal radius osteotomy 2. Status post open reduction internal fixation bone grafting of the distal radius osteotomy site along with distal ulnar resection3. Status post left wrist arthoscopy4. Internal diagnoses The utilization review report dated 12/08/14 denied the request for Continued post-operative occupational therapy 2 x 6 (left wrist/hand) and CPM machine/kit (rental or purchase) based on modification to 2x2 for postoperative therapy based on guidelines and medical necessity.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Continued post-operative occupational therapy 2 x 6 (left wrist/hand): Upheld**

**Claims Administrator guideline:** Decision based on MTUS Postsurgical Treatment Guidelines.

**MAXIMUS guideline:** Decision based on MTUS Postsurgical Treatment Guidelines.

**Decision rationale:** The patient presents with pain affecting her left wrist. The current request is for Continued post-operative occupational therapy 2 x 6 (left wrist/hand). The treating physician states, "She states that the occupational therapy was authorized and she has been receiving some treatment." The patient had 18 (3 times a week for 6 weeks) visits of post-operative occupational therapy approved. (17) The MTUS Post-Surgical Treatment guidelines allow up to 24 visits for this surgery. In this case, the treating physician has requested 12 sessions following the prior 18 sessions that were authorized. The current request exceeds the recommended total of 24 post surgical therapy sessions and is not medically necessary. Recommendation is for denial.

**CPM machine/kit (rental or purchase):** Overturned

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), ODG-TWC Forearm, Wrist & Hand Procedure Summary; Blue Cross of California Medical Policy #DME/00019: Continuous Passive Motion Devices Continuous passive motion (CPM)

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Wrist/Hand, Continuous passive motion.

**Decision rationale:** The patient presents with pain affecting her left wrist. The current request is for CPM machine/kit (rental or purchase). The treating physician states, "Request authorization for a CPM machine for the left wrist for range of motion, flexion, and extension." (21) MTUS guidelines do not address CPM machines. The ODG guidelines state, "Controlled mobilization regimens are widely employed in rehabilitation after flexor tendon repair in the hand." In this case, the treating physician has documented that the patient has undergone multiple surgeries for her wrist. The ODG guidelines do support this request and ODG does not restrict the request with any trials limiting a duration of usage. The current request is medically necessary and the recommendation is for authorization.