

<b>Case Number:</b>	CM15-0000147		
<b>Date Assigned:</b>	01/09/2015	<b>Date of Injury:</b>	05/01/2012
<b>Decision Date:</b>	03/12/2015	<b>UR Denial Date:</b>	12/16/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	12/31/2014

### 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: New York, Tennessee

Certification(s)/Specialty: Emergency Medicine

### 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 31 year old female, who sustained an industrial injury on May 1, 2012. She has reported bilateral wrist pain. The diagnoses have included DeQuervain's/Radial styloid tenosynovitis of the wrists. Treatment to date has included physical therapy, acupuncture, shockwave treatments, chiropractic manipulative therapy, bilateral thumb spica splinting, activity modifications, and off work. Currently, the injured worker complains of left wrist pain worse in the cold weather. On December 16, 2014 Utilization Review non-certified a prescription for 9 visits (3 x 3 weeks) OT (occupational therapy) with Ionophoresis for the left wrist, noting the lack of evidence of clearly established objective and measured functional gains, improvement with activities of daily living, or discussions regarding return to work as a result of previous physical therapy. In addition there was a lack of documentation of the number of physical therapy visits to date, no clear description of independent exercise instruction, compliance, or failure of an independent program to address residual effects. The Utilization Review modified a request for a splint for the left wrist, noting the guidelines support wrist and thumb splint in the treatment of DeQuervain's tenosynovitis. The California Medical Treatment Utilization Schedule (MTUS), Chronic Pain Medical Treatment Guidelines, ACOEM (American College of Occupational and Environmental Medicine), Forearm, Wrist and Hand Complaints were cited

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Occupational Therapy with Iontophoresis and Splint 3 times a week for 3 weeks left wrist:**  
Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 264, Chronic Pain Treatment Guidelines Physical Medicine Page(s): 98-99.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Pain Interventions and Guidelines Page(s): 98-99.

**Decision rationale:** Chronic Pain Medical Treatment Guidelines state that there is no high-grade scientific evidence to support the effectiveness or ineffectiveness of passive physical modalities such as traction, heat/cold applications, massage, diathermy, TENS units, ultrasound, laser treatment, or biofeedback. They can provide short-term relief during the early phases of treatment. Active treatment is associated with better outcomes and can be managed as a home exercise program with supervision. ODG states that physical therapy is more effective in short-term follow up. Patients should be formally assessed after a "six-visit clinical trial" to see if the patient is moving in a positive direction, no direction, or a negative direction (prior to continuing with the physical therapy). When treatment duration and/or number of visits exceed the guideline, exceptional factors should be noted. Recommended number of visits for myalgia and myositis is 9-10 visits over 8 weeks; and for neuralgia, neuritis, and radiculitis is 8-10 visits over 4 weeks. In the case the requested number of visits surpasses the six visits recommended as a clinical trial to determine if there is functional improvement. The request should not be authorized.