

<b>Case Number:</b>	CM15-0004282		
<b>Date Assigned:</b>	01/15/2015	<b>Date of Injury:</b>	06/12/2013
<b>Decision Date:</b>	03/19/2015	<b>UR Denial Date:</b>	12/30/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	01/08/2015

### 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

Certification(s)/Specialty: Orthopedic Surgery

### 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 50 year old female, who sustained an industrial injury on 6/12/2013. She has reported wrist pain and subsequently underwent left wrist arthroscopy with partial synovectomy on 7/20/14. The diagnoses have included wrist strain/sprain. Treatment to date has included Non-Steroidal Anti-Inflammatory Drugs (NSAIDs). Currently, the IW complains of increased pain left wrist. Physical examination from 12/17/14 documented limited flexion and extension, including fingers. Diagnoses included bilateral wrist strain and Triangular Fibrocartilage Complex (TFCC) tear. Plan of care included continuation of anti-inflammatory and six (6) physical therapy sessions. On 12/30/2014 Utilization Review modified certification for additional post operative physical therapy, once weekly for two weeks, QTY # 2 from 12/30/14 to 2/28/15. Utilization Review non-certified additional post operative physical therapy twice a week, left wrist, noting insufficient documentation of the number of prior physical therapy visits. The MTUS and OGD Guidelines were cited. On 1/8/2015, the injured worker submitted an application for IMR for review of additional post-operative physical therapy two (2) times a week for three (3) weeks, left wrist.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Additional Post-Op Physical Therapy 2 Times Weekly for 3 Weeks to The Left Wrist:**  
Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine.

**MAXIMUS guideline:** Decision based on MTUS Postsurgical Treatment Guidelines Page(s): 22.

**Decision rationale:** Per CA MTUS/Post Surgical Treatment guidelines, page 22TFCC injuries-debridement (arthroscopic) [DWC]:Postsurgical treatment:10 visits over 10 weeks\*Postsurgical physical medicine treatment period: 4 monthsThere is lack of demonstrated functional improvement in the exam note of 12/17/14 to warrant further visits. Therefore, the determination is for non-certification.