

<b>Case Number:</b>	CM15-0132029		
<b>Date Assigned:</b>	07/20/2015	<b>Date of Injury:</b>	09/09/2014
<b>Decision Date:</b>	08/17/2015	<b>UR Denial Date:</b>	06/19/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	07/08/2015

### 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: 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 63 year old female who sustained a work related injury September 9, 2014, after a trip and fall onto her right hand. She was diagnosed with a right closed fracture of the distal radius, splinted for a week, and then casted. According to physician's assistants notes, dated April 28, 2015, the injured worker presented with right wrist and hand pain. Current medication included Pantoprazole, Benicar, and Crestor. There is decreased range of motion with mild pain of the right wrist with flexion and extension. No pain with supination, pronation, and lateral movement of the right wrist. There is mild tenderness of the dorsal aspect of the right wrist. Diagnosis is documented as right wrist pain. Treatment plan included to continue with physical therapy and home exercise program. At issue, is the request for authorization for additional physical therapy, once weekly, right hand, wrist.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Additional physical therapy, once weekly, right hand/wrist Qty: 4: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines physical medicine Page(s): 99.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Forearm, Wrist, & Hand (Acute & Chronic), Physical therapy, Fracture of radius/ulna (forearm) (ICD9 813).

**Decision rationale:** The requested Additional physical therapy, once weekly, right hand/wrist Qty: 4 is not medically necessary. CA MTUS is silent. Official Disability Guidelines, Forearm, Wrist, & Hand (Acute & Chronic), Physical therapy, Fracture of radius/ulna (forearm) (ICD9 813), recommend: Medical treatment: 16 visits over 8 weeks, Post-surgical treatment: 16 visits over 8 week," and continued therapy with documented functional improvement. The injured worker was diagnosed with a right closed fracture of the distal radius, splinted for a week, and then casted. According to physician's assistant's notes, dated April 28, 2015, the injured worker presented with right wrist and hand pain. Current medication included Pantoprazole, Benicar, and Crestor. There is decreased range of motion with mild pain of the right wrist with flexion and extension. No pain with supination, pronation, and lateral movement of the right wrist. There is mild tenderness of the dorsal aspect of the right wrist. The treating physician did not document objective evidence of derived functional improvement from completed physical therapy sessions. Finally, the completed therapy sessions should have afforded sufficient time for instruction and supervision of a transition to a dynamic home exercise program. The criteria noted above not having been met, Additional physical therapy, once weekly, right hand/wrist Qty: 4 is not medically necessary.