

<b>Case Number:</b>	CM15-0145858		
<b>Date Assigned:</b>	08/06/2015	<b>Date of Injury:</b>	10/01/2012
<b>Decision Date:</b>	09/03/2015	<b>UR Denial Date:</b>	06/30/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	07/27/2015

### 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: Massachusetts

Certification(s)/Specialty: Physical Medicine & Rehabilitation, Pain Management

### 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 37 year old female, who sustained an industrial injury on 10-1-12. The injured worker has complaints of left wrist and hand pain and left hip pain. The documentation noted there was positive tenderness. The diagnoses have included sprains and strains of wrist and hand. Treatment to date has included physical therapy; magnetic resonance imaging (MRI) of neck and back and medications. The request was for physical therapy 3 x week x 4 weeks left wrist-hand & hip.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Physical therapy 3 x week x 4 weeks left wrist/hand & hip:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): Table 11-7.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) (1) Chronic pain, Physical medicine treatment. (2) Preface, Physical Therapy Guidelines.

**Decision rationale:** The claimant sustained a work-related injury in October 2012. When seen, there was left wrist and hand pain rated at 5/10 with numbness and tingling. There was outer left hip pain radiating down the side rated at 6/10. Physical examination findings included decreased left grip strength with pain. There was thenar and hypothenar tenderness. There was left acromioclavicular joint tenderness with positive drop arm test and decreased deltoid strength. There was left greater trochanteric bursa tenderness. Physical therapy and acupuncture were requested. The claimant is being treated for chronic pain with no new injury. In terms of physical therapy treatment for chronic pain, guidelines recommend a six visit clinical trial with a formal reassessment prior to continuing therapy. In this case, the number of visits requested is in excess of that recommended or what might be needed to determine whether continuation of physical therapy was likely to be effective. The request was not medically necessary.