

<b>Case Number:</b>	CM15-0183456		
<b>Date Assigned:</b>	09/24/2015	<b>Date of Injury:</b>	03/24/2015
<b>Decision Date:</b>	11/18/2015	<b>UR Denial Date:</b>	08/17/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	09/17/2015

### 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: Preventive Medicine, Occupational 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 28 year old male injured worker suffered an industrial injury on 3-24-2015. The diagnoses included fracture of the phalanx and crush injury to the left index finger. On 7-23-2015 the treating provider reported he was still having pain rated 5-10. Prior treatment included physical therapy sessions with noted progress. The Utilization Review on 8-17-2015 determined modification for Ultrasound twice weekly, left index finger per 7/23/15 order QTY: 6 to QTY: 4, Manual therapy, twice weekly, left index finger per 7/23/15 order QTY: 6 to QTY: 4, Electrical Stimulation, twice weekly, left index finger, per 7/23/15 order QTY: 6 to QTY: 4 and Therapeutic exercise, twice weekly, left index finger, per 7/23/15 order QTY: 6 to QTY: 4.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Ultrasound twice weekly, left index finger per 7/23/15 order QTY: 6: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**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), (Not including Carpal Tunnel Syndrome), Ultrasound (therapeutic).

**Decision rationale:** According to the Official Disability Guidelines, therapeutic ultrasound not recommended. In a Cochrane Database review, there was only weak evidence of a short-term benefit of therapeutic ultrasound for distal radial fractures. For arthritic hands, there is no significant benefit from therapeutic ultrasound for all the outcomes measured after 1, 2 or 3 week(s) of treatment. In this RCT, adding ultrasound therapy to splinting was not superior to splinting alone. Ultrasound twice weekly, left index finger per 7/23/15 order QTY: 6 is not medically necessary.

**Manual therapy, twice weekly, left index finger per 7/23/15 order QTY: 6: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Manual therapy & manipulation.

**Decision rationale:** The MTUS Chronic Pain Medical Treatment Guidelines state that active therapy is based on the philosophy that therapeutic exercise and/or activity are beneficial for restoring flexibility, strength, endurance, function, range of motion, and can alleviate discomfort. Patients are instructed and expected to continue active therapies at home as an extension of the treatment process in order to maintain improvement levels. As the patient has already completed 6 sessions of therapy, the original reviewer modified the request to 4 sessions to comply with the MTUS Guidelines. Manual therapy, twice weekly, left index finger per 7/23/15 order QTY: 6 is not medically necessary.

**Electrical Stimulation, twice weekly, left index finger, per 7/23/15 order QTY: 6: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**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), Electrical muscle stimulation (EMS).

**Decision rationale:** The Official Disability Guidelines state that electrical muscle stimulation is not recommended. There is limited evidence of no benefit from electric muscle stimulation compared to a sham control for pain in chronic mechanical hand disorders (MND). Most characteristics of EMS are comparable to TENS. Electrical Stimulation, twice weekly, left index finger, per 7/23/15 order QTY: 6 is not medically necessary.

**Therapeutic exercise, twice weekly, left index finger, per 7/23/15 order QTY: 6: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Manual therapy & manipulation.

**Decision rationale:** Passive therapy (those treatment modalities that do not require energy expenditure on the part of the patient) can provide short term relief during the early phases of pain treatment and are directed at controlling symptoms such as pain, inflammation and swelling and to improve the rate of healing soft tissue injuries. As the patient has already completed 6 sessions of therapy, the original reviewer modified the request to 4 sessions to comply with the MTUS Guidelines. Therapeutic exercise, twice weekly, left index finger, per 7/23/15 order QTY: 6 is not medically necessary.