

<b>Case Number:</b>	CM15-0028549		
<b>Date Assigned:</b>	02/20/2015	<b>Date of Injury:</b>	06/22/2014
<b>Decision Date:</b>	04/07/2015	<b>UR Denial Date:</b>	01/15/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	02/13/2015

### 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: Internal 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 26-year-old male who sustained an industrial injury on 6/22/14. The injured worker reported symptoms in the right upper extremity. The diagnoses included triangular fibrocartilage complex tear. Treatments to date include repair of partial dorsal triangular fibrocartilage complex tear on 10/17/14, Occupational Therapy, activity modification, long arm splint, and ice application. In a progress note dated 1/8/15 the treating provider reports the injured worker was with "mild tenderness dorsal-ulnar aspect of the right wrist, full range of motion in all digits right hand and full supination and pronation." On 1/14/15 Utilization Review modified the request for Occupational Therapy right wrist 3 times a week for 4 weeks, 12 sessions to 4 additional Occupational Therapy sessions for instruction and monitoring of an independent home exercise program. The MTUS, ACOEM Guidelines, (or ODG) was cited.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Occupational Therapy Right Wrist 3 times a week for 4 weeks, 12 sessions:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Postsurgical Treatment Guidelines. Decision based on Non-MTUS Citation ODG Physical/Occupational Therapy Guidelines.

**MAXIMUS guideline:** Decision based on MTUS Postsurgical Treatment Guidelines.

**Decision rationale:** Medical Treatment Utilization Schedule (MTUS) addresses post-operative physical therapy (PT) physical medicine. The Postsurgical Treatment Guidelines indicate that for TFCC arthroscopic surgery, 10 visits of postsurgical physical therapy are recommended. The hand therapy progress report dated 1/5/15 document that the patient had completed 6 visits out of a total of 12 visits of occupational therapy. The treating physician's progress report dated 1/8/15 documented mild tenderness dorsal-ulnar aspect of the right wrist, no instability. Right wrist flexion was 50 degrees, and extension was 60 degrees. Full range of motion in all digits of the right hand, and full supination and pronation were noted. The patient was status post triangular fibrocartilage complex (TFCC) surgery. The request for authorization dated 1/15/15 documented a request for occupational therapy three times a week for four weeks (12). The request for 12 additional occupational therapy visits exceeds MTUS Postsurgical Treatment Guidelines, and is not supported. Therefore, the request for 12 additional occupational therapy visits is not medically necessary.