

Case Number:	CM14-0081594		
Date Assigned:	07/18/2014	Date of Injury:	04/23/2012
Decision Date:	09/24/2014	UR Denial Date:	05/30/2014
Priority:	Standard	Application Received:	06/02/2014

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. The expert reviewer is Board Certified in Physical Medicine and Rehabilitation and is licensed to practice in Texas. 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

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 40 year old female who sustained an injury to her left wrist on 04/23/12. The mechanism of injury was not documented. Magnetic resonance image of the left wrist dated 10/02/13 revealed no ulnar variant; small areas of decreased signal intensity in the capitate indicative of mild osteonecrosis; fluid seen between the distal ulna and navicular; no fluid between the distal ulna and the radius indicating the integrity of the fibrocartilage of the triangular ligament; no soft tissue or muscular abnormalities; flexor/extensor tendons intact. The clinical note dated 05/29/14 reported that the injured worker continued to complain of soreness, stiffness, swelling, tenderness, pain, tingling, and weakness of the left wrist at 3/10 visual analog scale. The injured worker also complained of reduced functional abilities including activities of daily living, household chores, carrying light objects, etc. A temporary relief of symptoms is reported from medication and heat. Treatment to date has included electrical stimulation, connective tissue massage, moist heat, therapeutic exercises. Physical examination noted manual muscle testing 3+/5 with flexion, extension, ulnar deviation and pronation, ulnar deviation, radial deviation and supination 3/5. The injured worker was diagnosed with a left wrist sprain and recommended to continue the aforementioned treatment modalities.

IMR ISSUES, DECISIONS AND RATIONALES

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

Additional Physical Therapy 2 x week for 6 weeks = 12 Total, Left wrist: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Exercise.

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 and hand chapter, Physical/ Occupational therapy.

Decision rationale: The injured worker has received at least 16 visits. There was no reported objective or subjective benefits from physical therapy to date. There was no indication as to why she is unable to continue her rehabilitation on a home exercise basis. There was no additional significant objective clinical information provided for review that would support the need to exceed the current guideline recommendations. Given this, the request for additional Physical Therapy 2 x a week x 6 weeks equal 12 for the Left Wrist are not medically necessary.

Left wrist Rehab Kit: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Exercise.

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 and hand chapter, Exercises.

Decision rationale: Normal daily activity can be considered part of a home exercise program. The injured worker is not indicated to have failed a home exercise program without the use of equipment. After reviewing the submitted documentation, there was no additional significant objective clinical information provided that would support reversing the previous adverse determination. Given this, the request for a Left Wrist Rehab Kit is not medically necessary.