

<b>Case Number:</b>	CM15-0017917		
<b>Date Assigned:</b>	02/05/2015	<b>Date of Injury:</b>	04/02/2013
<b>Decision Date:</b>	03/25/2015	<b>UR Denial Date:</b>	01/09/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	01/30/2015

### 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: Physical Medicine & Rehabilitation

### CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

This 49-year-old male sustained a work related injury on 04/02/2013. The injury occurred when he fell through a ceiling 31 feet onto a concrete floor. The injured worker underwent emergency treatment that consisted of orthopedic procedures to the left lower extremity. He had a crush injury to L4 and suffered fractures of the bilateral feet. On 04/14/2013, the injured worker underwent open reduction and internal fixation right distal radius intraarticular fragments x 2, open reduction and internal fixation right scaphoid, triquetrum and peri lunate dislocation. According to a consultation noted dated 06/26/2013, the injured worker complained of constant moderate to moderately severe pain. Concerning his wrist, he had no functional capacity for either force or repetition or motion. The injured worker demonstrated only 10 degrees of right wrist flexion/extension motion. He only demonstrated 5 degrees of radial to ulnar motion. On 01/15/2014, the injured worker underwent right wrist hardware removal x 2, proximal row corpectomy, radial styloidectomy, posterior and anterior interosseous nerve resection and volar radiocarpal ligament repair. The injured worker attended physical therapy following the surgery. On 01/09/2015, Utilization Review modified physical therapy 3 x 6 for the right wrist. According to the Utilization Review physician, the record review did not specify the scope, nature and outcome of prior therapy for this clinical presentation of status post right proximal row corpectomy and volar radial collateral ligament repair on 01/15/2014. Guidelines cited for this review included CA MTUS Chronic Pain Medical Treatment Guidelines page 99, Physical Medicine. The decision was appealed for an Independent Medical Review.

## IMR ISSUES, DECISIONS AND RATIONALES

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

**Physical therapy 3 x 6 of the right wrist:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Page(s): 99. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Forearm, Wrist, & Hand

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Physical Therapy Page(s): 98-99.

**Decision rationale:** Physical therapy is considered medically necessary when the services require the judgment, knowledge, and skills of a qualified physical therapist due to the complexity and sophistication of the therapy and the physical condition of the patient. However, there is no clear measurable evidence of progress with the PT treatment already rendered including milestones of increased ROM, strength, and functional capacity. Review of submitted physician reports show no evidence of functional benefit, unchanged chronic symptom complaints, clinical findings, and functional status. There is no evidence documenting functional baseline with clear goals to be reached and the patient striving to reach those goals. The Chronic Pain Guidelines allow for 9-10 visits of physical therapy with fading of treatment to an independent self-directed home program. It appears the employee has received significant therapy sessions without demonstrated evidence of functional improvement to allow for additional therapy treatments. There is no report of acute flare-up, new injuries, or change in symptom or clinical findings to support for formal PT in a patient that has been instructed on a home exercise program for this chronic injury. Submitted reports have not adequately demonstrated the indication to support further physical therapy when prior treatment rendered has not resulted in any functional benefit. The physical therapy is not medically necessary and appropriate.