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| Case Number: | CM15-0098287 | | |
| Date Assigned: | 05/29/2015 | Date of Injury: | 07/20/2011 |
| Decision Date: | 06/30/2015 | UR Denial Date: | 05/06/2015 |
| Priority: | Standard | Application Received: | 05/21/2015 |

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, 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 (IW) is a 52 year old who sustained an industrial injury on 07/20/2011. She reported a painful mass on the dorsal (back) aspect of the right wrist. The injured worker was diagnosed as having a ganglion cyst; flexor carpiulnaris Tendonitis right wrist. Treatment to date has included arthroscopic surgery for triangular fibrocartilage complex cartilage debridement and ganglion cyst excision for the right wrist in 2/2015, followed by 23 post op physical therapy visits. Currently, the injured worker complains of pain on the volar-ulnar aspect of the right wrist. On exam there is mild tenderness and swelling at the dorsum of the right wrist. The IW has 55 degrees of flexion and 60 degrees extension with full range of motion in all digits of the right hand. Treatment plan is to dispense current medications of Voltaren, Protonix and Ultram, and continue occupational therapy 3x4, for the right wrist.

IMR ISSUES, DECISIONS AND RATIONALES

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

Occupational therapy 3x4, right wrist: Upheld

Claims Administrator guideline: Decision based on MTUS Postsurgical Treatment Guidelines.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 265, Postsurgical Treatment Guidelines Page(s): 8-22. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Forearm, Wrist, & Hand Chapter, Physical/Occupational Therapy.

Decision rationale: Regarding the request for additional physical therapy, Chronic Pain Medical Treatment Guidelines recommend a short course of active therapy with continuation of active therapies at home as an extension of the treatment process in order to maintain improvement levels. ODG has more specific criteria for the ongoing use of physical therapy. ODG recommends a trial of physical therapy. If the trial of physical therapy results in objective functional improvement, as well as ongoing objective treatment goals, then additional therapy may be considered. Within the documentation available for review, there is documentation of completion of prior PT sessions, but there is no documentation of specific objective functional improvement with the previous sessions and remaining deficits that cannot be addressed within the context of an independent home exercise program, yet are expected to improve with formal supervised therapy. Furthermore, the request exceeds the amount of PT recommended by the CA MTUS for this patient's diagnoses and, unfortunately, there is no provision for modification of the current request. In light of the above issues, the currently requested additional physical therapy is not medically necessary.