

<b>Case Number:</b>	CM14-0117769		
<b>Date Assigned:</b>	08/06/2014	<b>Date of Injury:</b>	01/24/2013
<b>Decision Date:</b>	09/23/2014	<b>UR Denial Date:</b>	06/24/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	07/28/2014

### 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 Orthopaedic Surgery and is licensed to practice in California. 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:

This 47-year-old female sustained an industrial injury on 1/24/13. Injury occurred when she went to sit down and her chair rolled away. She fell, placing her right arm out to break her fall. Past medical history was positive for right carpal tunnel syndrome controlled with conservative treatment. A 7/2/12 electrodiagnostic study demonstrated moderate right carpal tunnel syndrome. The patient underwent right shoulder arthroscopic debridement of the rotator cuff and glenoid labrum, acromioplasty, and distal clavicle resection on 11/23/13. Records indicated that 24 post-operative physical therapy visits had been provided. The 3/11/14 treating physician initial report cited complaints of right shoulder and wrist pain with numbness and tingling in the upper extremity. Right shoulder exam documented range of motion as forward flexion 140, abduction 130, external rotation 70 and internal rotation 80 degrees with negative impingement signs. Right wrist exam documented moderate to severe volar wrist tenderness, positive Tinel's sign, positive Phalen's, mild to moderate loss of dorsiflexion and palmar flexion, decreased grip strength, and negative Finkelstein's. The treatment plan recommended medications, topical creams, and additional physical therapy. Records were requested, including EMG/NCV tests. The 6/5/14 treating physician progress report indicated the patient felt better after the right wrist corticosteroid injection. She reported continued intermittent right wrist pain with numbness and tingling, and difficulty sleeping. There were no exam findings documented. The treatment plan requested physical therapy 2x6 for the right shoulder. Authorization was requested for right carpal tunnel release as recommended by the orthopedist. The 6/24/14 utilization review denied the request for right shoulder physical therapy as there was no documentation to support the medical necessity of additional supervised physical therapy over home exercise program. The request for right carpal tunnel release was denied as there was no electrodiagnostic evidence to confirm the diagnosis of carpal tunnel syndrome.

## IMR ISSUES, DECISIONS AND RATIONALES

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

**PT 2x6 Right shoulder:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Physical medicine Page(s): 98.

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

**Decision rationale:** California MTUS Post-Surgical Treatment Guidelines do not apply to this case as the 6-month post-surgical treatment period had expired. MTUS Chronic Pain Medical Treatment Guidelines would apply. The MTUS guidelines recommend therapies focused on the goal of functional restoration rather than merely the elimination of pain. The physical therapy guidelines state that patients are expected to continue active therapies at home as an extension of treatment and to maintain improvement. There are no current exam findings or functional assessment to support the medical necessity of this request. The patient had completed the recommended general course of post-op physical therapy, 24 visits. The medical necessity of additional supervised physical therapy over independent home exercise is not established. Therefore, this request is not medically necessary.

**Right Carpal Tunnel release:** Overturned

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 270.

**Decision rationale:** The California MTUS guidelines state that carpal tunnel syndrome should be proved by positive findings on clinical exam and the diagnosis should be supported by nerve conduction tests before surgery is undertaken. Criteria include failure to respond to conservative management, including worksite modification. Guideline criteria have been met. Records documented positive clinical exam findings and electrodiagnostic evidence of carpal tunnel syndrome. Reasonable conservative treatment has been provided and has failed to produce sustained benefit. Therefore, this request is medically necessary.