

<b>Case Number:</b>	CM14-0055006		
<b>Date Assigned:</b>	07/07/2014	<b>Date of Injury:</b>	10/21/2013
<b>Decision Date:</b>	09/05/2014	<b>UR Denial Date:</b>	04/09/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	04/24/2014

### 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 Occupational Medicine 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:

300 pages were provided for review. Per these records, the claimant was 51 years old at the time of the review. The injury was 10-21-13. There was left upper extremity brachial plexopathy, a left wrist triangular fibrocartilage tear and left shoulder tear status post dislocation. Physical therapy was started and it was helping. The range of motion of the finger improved, but he still could not oppose the 1st and 5th digits. The left shoulder shows impingement. 35 occupational therapy as of April 1 was noted. The therapy orders from 4-1-14 gave a diagnosis of complete rupture of the rotator cuff, closed dislocation of other site of the shoulder, and pain in the hand. The occupational therapist noted on April 1 that there was still left hand and wrist pain, and left shoulder pain. The pain in the shoulder was 5 out of 10. The 12-27-13 exam noted he had a traumatic injury to the left shoulder with a traction injury, so he had rotator cuff damage and alleged brachial plexopathy. His left arm reportedly was paralyzed for some time after the injury. There is minimal active motion of all digits. Passive motion is difficult secondary to stiffness and discomfort. The MRI from 11-1-13 showed a probable triangular fibrocartilage tear. X-rays may show degenerative changes at the basilar joint of the thumb. The doctor thinks he has swelling from lack of use, not the tear. The passive therapy he believes will help him regain motion in the hands. A PR2 from 3-26-14 gives diagnoses of left upper extremity brachial plexopathy, a left wrist triangular fibrocartilage tear, and a left shoulder tear status post dislocation. Range of motion of the fingers is improved. Many therapy notes were provided.

### IMR ISSUES, DECISIONS AND RATIONALES

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

## **Occupational Therapy Left Shoulder Two Times A Week For Six Weeks: Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines 8 C.C.R. 9792.20 - 9792.26 MTUS (Effective July 18, 2009) Page(s): 98 of 127.

**Decision rationale:** The MTUS does permit physical therapy in chronic situations, noting however that one should allow for fading of treatment frequency (from up to 3 visits per week to 1 or less), plus active self-directed home Physical Medicine. The conditions mentioned are Myalgia and myositis, unspecified (ICD9 729.1): 9-10 visits over 8 weeks; Neuralgia, neuritis, and radiculitis, unspecified (ICD9 729.2) 8-10 visits over 4 weeks; and Reflex sympathetic dystrophy (CRPS) (ICD9 337.2): 24 visits over 16 weeks. This claimant does not have these conditions. There is no evidence of fading of the treatment to self-care. In fact, after 35 sessions, it is not clear why the patient would not be independent with self-care at this point. Also, there are especially strong caveats in the MTUS/ACOEM guidelines against over treatment in the chronic situation supporting the clinical notion that the move to independence and an active, independent home program is clinically in the best interest of the patient. They cite: 1. Although mistreating or under treating pain is of concern, an even greater risk for the physician is over treating the chronic pain patient. Over treatment often results in irreparable harm to the patient's socioeconomic status, home life, personal relationships, and quality of life in general. 2. A patient's complaints of pain should be acknowledged. Patient and clinician should remain focused on the ultimate goal of rehabilitation leading to optimal functional recovery, decreased healthcare utilization, and maximal self actualization. This request for more skilled, monitored therapy was appropriately non-certified.

## **Occupational Therapy Left Hand Two Times A Week For Six Weeks: Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines 8 C.C.R. 9792.20 - 9792.26 MTUS (Effective July 18, 2009) Page(s): 98 of 127.

**Decision rationale:** As shared previously, the MTUS does permit physical therapy in chronic situations, noting that one should allow for fading of treatment frequency (from up to 3 visits per week to 1 or less), plus active self-directed home Physical Medicine. The conditions mentioned are Myalgia and myositis, unspecified (ICD9 729.1): 9-10 visits over 8 weeks; Neuralgia, neuritis, and radiculitis, unspecified (ICD9 729.2) 8-10 visits over 4 weeks; and Reflex sympathetic dystrophy (CRPS) (ICD9 337.2): 24 visits over 16 weeks. This claimant does not have these conditions. And, after 35 sessions, it is not clear why the patient would not be independent with self-care at this point. Also, there are especially strong caveats in the MTUS/ACOEM guidelines against over treatment in the chronic situation supporting the clinical notion that the move to independence and an active, independent home program is clinically in the best interest of the patient. They cite: 'Although mistreating or under treating pain is of

concern, an even greater risk for the physician is over treating the chronic pain patient...Over treatment often results in irreparable harm to the patient's socioeconomic status, home life, personal relationships, and quality of life in general." A patient's complaints of pain should be acknowledged. Patient and clinician should remain focused on the ultimate goal of rehabilitation leading to optimal functional recovery, decreased healthcare utilization, and maximal self actualization.' Again, this request for more skilled, monitored therapy was appropriately non-certified.