

<b>Case Number:</b>	CM14-0094578		
<b>Date Assigned:</b>	09/10/2014	<b>Date of Injury:</b>	01/20/2014
<b>Decision Date:</b>	11/03/2014	<b>UR Denial Date:</b>	06/13/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	06/22/2014

### 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 & Rehabilitation, 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:

The injured worker is a 47-year-old male who sustained an injury on January 20, 2014. He is diagnosed with (a) contusion of forearm, (b) crushing injury of forearm, (c) affections shoulder region, (d) chronic pain syndrome, (e) carpal tunnel syndrome, (f) lesion of ulnar nerve, (g) sprain/strain of neck, and (h) mononeuritis arm. He was seen for an evaluation on May 28, 2014. He presented with complaints of left forearm and wrist pain, left elbow pain, neck pain, and left shoulder pain. Examination of the left forearm and wrist revealed significantly decreased coolness of the hand and significantly decreased tenderness. Range of motion was limited. Grasp was moderately weak. Examination of the left elbow revealed limited range of motion. Examination of the left shoulder revealed moderate tenderness over the anterior acromion and bicipital groove. Range of motion was limited. Drop arm testing demonstrated the rotator cuff to be functional in both pronation and supination with and without resistance. Biceps and triceps were rated 4/5 bilaterally. Examination of the cervicothoracic spine revealed tightness and tenderness over the paravertebral musculature and cervicothoracic junction bilaterally, left side greater than the right side. Range of motion was decreased.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Physical therapy 2xwk x 6wks left wrist/hand/shoulder Qty: 12: Upheld**

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

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

**Decision rationale:** Guidelines stated that objective functional improvement must be documented to warrant further sessions of therapy. It has also been determined that the injured worker exceeded the number of sessions of physical therapy recommended by the guidelines. Therefore, the requested 12 sessions of physical therapy to the left wrist, hand, and shoulder is not medically necessary at this time.