

<b>Case Number:</b>	CM15-0145512		
<b>Date Assigned:</b>	08/06/2015	<b>Date of Injury:</b>	04/25/2013
<b>Decision Date:</b>	09/09/2015	<b>UR Denial Date:</b>	07/20/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	07/27/2015

### 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, Hawaii  
 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:

The injured worker is a 53 year old female who sustained an industrial injury on April 25, 2013. A recent primary treating office visit dated July 07, 2015 reported subjective complaint of left shoulder pain. She is status post left shoulder surgery in April 2014. There is also complaint of compensatory right shoulder pain, cervical pain with left upper extremity greater. There is left wrist pain. She states the topical cream being denied and she has trialed non-steroidal anti-inflammatory agent and Celebrex. Current medications are: Hydrocodone 7.5 mg three times daily along with Omeprazole. The following diagnoses were applied: status post left shoulder surgery, cervical pain with upper extremity symptoms, left facial pain, and compensatory right shoulder pain, rule out impingement or rotator cuff pathology. The plan of care noted continuing recommendation for a course of physical therapy treating left shoulder and cervical spine; undergo magnetic resonance imaging scan of right shoulder, and continue with medication regimen.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**12 visits of physical Therapy left wrist: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints, Chronic Pain Treatment Guidelines Physical Medicine. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Forearm, Wrist & Hand (Acute & Chronic).

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

**Decision rationale:** The patient presents with pain affecting the right shoulder, cervical spine, left upper extremity and left wrist. The current request is for 12 visits of physical Therapy left wrist. The treating physician report dated 7/7/15 (13B) states, Continue with request for physical therapy left wrist at 3 times per week for 4 weeks, Emphasis on active therapy. MTUS supports physical medicine (physical therapy and occupational therapy) 8-10 sessions for myalgia and neuritis type conditions. The MTUS guidelines only provide a total of 8-10 sessions and the patient is expected to then continue on with a home exercise program. The patient's status is not post-surgical. The medical reports provided show the patient has received at least 18 visits of prior physical therapy, although it is uncertain the quantity of sessions that were dedicated to the left wrist. In this case, the patient has received at least 18 visits of physical therapy to date and the current request of 12 visits exceeds the recommendation of 8-10 visits as outlined by the MTUS guidelines on page 99. Furthermore, there was no rationale by the physician in the documents provided as to why the patient requires treatment above and beyond the MTUS guidelines. The current request is not medically necessary.