

<b>Case Number:</b>	CM15-0145971		
<b>Date Assigned:</b>	08/06/2015	<b>Date of Injury:</b>	04/29/2013
<b>Decision Date:</b>	09/10/2015	<b>UR Denial Date:</b>	07/06/2015
<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

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 male who sustained an industrial injury on 4-29-13. In an interim report dated 5-28-15, the primary treating physician notes the injured worker reports persistent symptoms to the wrist. On exam there was weakness to the right wrist and no tenderness. The left shoulder range of motion in forward flexion was from 0-180 degrees, external rotation was from 0-40 degrees, and internal rotation was to T6. There was improved strength abduction testing. Diagnoses are status post left shoulder arthroscopy with subacromial decompression with rotator cuff repair, right wrist ligament injuries triangular fibrocartilage complex tear, right carpal tunnel syndrome, and right wrist fusion. Previous treatment includes at least 10 physical therapy visits. An operative report dated 12-10-14 notes procedures performed as right wrist fusion and right carpal tunnel release. Work status is noted as temporary total disability. The requested treatment is physical therapy for the left shoulder and right wrist 2 times a week for 4 weeks.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Physical therapy for the left shoulder and right wrist 2 times a week for 4 weeks:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Page(s): 99.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine, Postsurgical Treatment Guidelines Page(s): 15.

**Decision rationale:** The patient was injured on 04/29/13 and presents with left shoulder pain and right wrist pain. The request is for PHYSICAL THERAPY FOR THE LEFT SHOULDER AND RIGHT WRIST 2 TIMES A WEEK FOR 4 WEEKS. There is no RFA provided and the patient is on temporary total disability. MTUS Post-Surgical Guidelines, Carpal Tunnel Syndrome, page 15 indicates that the patient is allowed to have 3-8 visits over 3-5 weeks. The postsurgical treatment period is 3 months. MTUS Guidelines, Physical Medicine, pages 98 and 99 have the following: Physical medicine: Recommended as an indicated below. Allow for fading of treatments frequency (from up to 3 visits per week to 1 or less), plus active self-directed home Physical Medicine. MTUS Guidelines pages 98 and 99 state that for myalgia, myositis, 9 to 10 visits are recommended over 8 weeks, and for neuralgia, neuritis, and radiculitis, 8 to 10 visits are recommended. The patient has tenderness over the wrist and is diagnosed with status post left shoulder arthroscopy with subacromial decompression with rotator cuff repair, right wrist ligament injuries triangular fibrocartilage complex tear, right carpal tunnel syndrome, and right wrist fusion. On 12/10/14, the patient underwent a right wrist fusion and right carpal tunnel release. The patient has had at least 16 sessions of physical therapy to the right wrist from 01/09/15 to 03/02/15. The patient is no longer in the post-operative time frame; therefore, MTUS Guidelines pages 98-99 were referred to. In this case, the request is for 8 sessions of physical therapy of the patient's left shoulder and right wrist. However, there is no numerical assessment to indicate how prior physical therapy sessions impacted the patient's pain and function. There is no discussion regarding why the patient is unable to establish a home exercise program to manage his pain. There is no indication of any flare up the patient may have to allow for additional therapy. Therefore, the request IS NOT medically necessary.