

<b>Case Number:</b>	CM15-0147990		
<b>Date Assigned:</b>	08/11/2015	<b>Date of Injury:</b>	06/05/2013
<b>Decision Date:</b>	09/10/2015	<b>UR Denial Date:</b>	07/08/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	07/30/2015

### 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, Pain Management

### 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 (n) 57 year old female, who sustained an industrial injury on 6-5-13. She reported injury to her left wrist. The injured worker was diagnosed as having left lateral epicondylitis, left carpal tunnel syndrome and left C7 radiculopathy. Treatment to date has included an EMG study in 1-2014 showing bilateral carpal tunnel syndrome, psychiatric treatments, physical therapy for the left shoulder, Tramadol and Flexeril. As of the PR2 dated 5-28-15, the injured worker reports some improvement in left shoulder pain following arthroscopic surgery. She continues to have problem with severe neck pain and left upper extremity radiating symptoms. Objective findings include restricted cervical range of motion, a persistent left carpal tunnel Tinel and left upper extremity weakness. The treating physician requested physical therapy 3 x weekly for 4 weeks for the left wrist.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Physical Therapy, Left Wrist, 3 times week for 4 weeks, 12 sessions:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 265. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Carpal Tunnel Syndrome Chapter, Physical medicine treatment.

**Decision rationale:** Regarding the request for physical therapy, Chronic Pain Medical Treatment Guidelines recommend a short course of active therapy with continuation of active therapies at home as an extension of the treatment process in order to maintain improvement levels. ODG has more specific criteria for the ongoing use of physical therapy. ODG recommends a trial of physical therapy. If the trial of physical therapy results in objective functional improvement, as well as ongoing objective treatment goals, then additional therapy may be considered. ODG recommends 1-3 visits for medical treatment of CTS. Within the documentation available for review, there is no indication of any specific objective treatment goals and no statement indicating why an independent program of home exercise would be insufficient to address any objective deficits. Furthermore, the request exceeds the amount of PT recommended by the CA MTUS and, unfortunately, there is no provision for modification of the current request. In the absence of such documentation, the current request for physical therapy is not medically necessary.