

Case Number:	CM15-0214495		
Date Assigned:	11/04/2015	Date of Injury:	06/10/2011
Decision Date:	12/15/2015	UR Denial Date:	10/02/2015
Priority:	Standard	Application Received:	10/30/2015

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, Indiana, New York
 Certification(s)/Specialty: Internal Medicine

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 59 year old male, who sustained an industrial injury on 6-10-11. Medical records indicate that the injured worker is undergoing treatment for status-post open reduction and internal fixation at the right distal ulna and radius with residuals and status-post right shoulder biceps tenodesis with residuals. The injured worker is currently not working. On (9-18-15) the injured worker complained of intermittent right shoulder pain with an occasional popping sensation. The injured worker also noted episodes of numbness and tingling in the right upper extremity. The pain is present 50% of the time and was rated most days at 3-4 out of 10 on the visual analog scale. On a bad day the pain was rated 5-6 out of 10. The pain increased with reaching, moving his arms backwards and lifting his upper extremity above the shoulder level. The injured worker also noted continuous right wrist and hand pain with associated numbness and tingling in the right upper extremity. The pain was rated 4-5 out of 10 most days. The pain increased with gripping, grasping, flexion and extension and repetitive hand and finger movements. Objective findings revealed mild to modified tenderness to palpation of the right shoulder and a decreased range of motion. An impingement test, Neer's sign and Hawkins's sign were positive in the right shoulder. Right wrist examination revealed tenderness to palpation of the wrist and over the distal aspect of the right ulna. Range of motion was decreased. Orthopedic testing was negative. A sensation deficit was noted over the right upper extremity. Treatment and evaluation to date has included medications, x-rays, post-operative physical therapy to the right wrist (6), MRI of the right shoulder, Cortisone injection to the right shoulder, physical therapy for the right shoulder (unspecified amount) and a right rotator cuff tear repair with a revision. Current medications include Citalopram, Lovastatin, Lisinopril and Hydrocodone. The Request for Authorization dated 9-18-15 included a request for physical therapy to the right upper extremity

to include the right shoulder and wrist twice a week for four weeks. The Utilization Review documentation dated 10-2-15 non-certified the request for physical therapy to the right upper extremity to include the right shoulder and wrist twice a week for four weeks.

IMR ISSUES, DECISIONS AND RATIONALES

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

Physical therapy to the right upper extremity, which includes the right shoulder and wrist twice a week for four weeks: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Physical Medicine.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Physical Medicine. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Forearm, wrist, and hand section, Physical therapy, Shoulder section, Physical therapy.

Decision rationale: Pursuant to the Chronic Pain Medical Treatment Guidelines and the Official Disability Guidelines, physical therapy to the right upper extremity, which includes the right shoulder and wrist twice a week for four weeks, is not medically necessary. Patients should be formally assessed after a six visit clinical trial to see if the patient is moving in a positive direction, no direction or negative direction (prior to continuing with physical therapy). When treatment duration and/or number of visits exceed the guideline, exceptional factors should be noted. In this case, the injured worker's working diagnoses are status post open reduction internal fixation right distal ulna and radius with residuals; and status post right shoulder biceps tenodesis with residuals. Date of injury is June 10, 2011. Request for authorization is October 1, 2015. The documentation shows the injured worker underwent right wrist surgery, right rotator cuff repair, and revision wrist surgery June 2013. According to a September 18, 2015 initial orthopedic evaluation, subjective complaints include ongoing right shoulder pain, right arm, wrist and hand pain. Objectively, right shoulder range of motion is decreased with positive impingement. There is tenderness of the right wrist with decreased range of motion and decrease in motor strength. Multiple physical therapy progress notes are scattered throughout the medical record. The total number of physical therapy sessions is not specified. There is no documentation demonstrating objective functional improvement to support ongoing/additional physical therapy. There are no compelling clinical facts indicating additional physical therapy (over the recommended guidelines) is clinically indicated. Based on the clinical information in the medical record, peer-reviewed evidence-based guidelines, no documentation specifying the total number of physical therapy sessions to date, no documentation demonstrating objective functional improvement and no compelling clinical facts indicating additional physical therapy is warranted, physical therapy to the right upper extremity, which includes the right shoulder and wrist twice a week for four weeks, is not medically necessary.