

<b>Case Number:</b>	CM15-0222095		
<b>Date Assigned:</b>	11/17/2015	<b>Date of Injury:</b>	07/06/2014
<b>Decision Date:</b>	12/30/2015	<b>UR Denial Date:</b>	10/16/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	11/10/2015

### 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: Iowa, Illinois, California

Certification(s)/Specialty: Preventive Medicine, Occupational Medicine, Public Health & General Preventive 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 47 year old female, who sustained an industrial injury on 7-6-14. The injured worker was being treated for sprain of right shoulder and right wrist and traumatic rupture of ligament of right index finger. On 10-9-15, the injured worker complains of left anterior shoulder, arm, elbow, forearm, wrist and hand; left posterior shoulder, arm, elbow, forearm, and wrist and left posterior hand pain with numbness and tingling. She also complains of dizziness, anxiety, stress and insomnia. She notes her symptoms improved with physical therapy, pain medication and rest. Work status is temporarily totally disabled. Physical exam performed on 10-9-15 revealed evidence of impingement of left shoulder with decreased range of motion and possible carpal tunnel syndrome of left wrist. MRI of left shoulder performed on 4-12-15 revealed impingement with down sloping of acromion process impinging on supraspinatus tendon in rotator cuff and tear at point of impingement and MRI of left wrist performed on 4-12-15 revealed some increased signal beneath transverse retinaculum near the median nerve which may represent carpal tunnel syndrome. Treatment to date has included physical therapy (which improved pain; however unknown number of visits completed), oral medications including Ibuprofen and Prilosec and activity modifications. On 10-9-15 request for authorization was submitted for 6 physical therapy visits to left shoulder and left wrist, Ibuprofen 600mg #90, Prilosec 20mg #60 and follow up appointment. On 10-16 request for 6 physical therapy visits to left shoulder was non-certified by utilization review.

## IMR ISSUES, DECISIONS AND RATIONALES

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

**Six (6) physical therapy 2 times per week for 3 weeks for left shoulder:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG).

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Physical Medicine. Decision based on Non-MTUS Citation Shoulder (Acute & Chronic), Physical Therapy, ODG Preface - Physical Therapy.

**Decision rationale:** California MTUS guidelines refer to physical medicine guidelines for physical therapy. "Allow for fading of treatment frequency (from up to 3 visits per week to 1 or less), plus active self-directed home Physical Medicine." Regarding physical therapy, ODG states "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 a negative direction (prior to continuing with the physical therapy); & (6) When treatment duration and/or number of visits exceeds the guideline, exceptional factors should be noted. Sprained shoulder; rotator cuff (ICD9 840; 840.4): Medical treatment: 10 visits over 8 weeks; Medical treatment, partial tear: 20 visits over 10 weeks The medical documentation provided is unclear in regards to the patient's previous physical therapy. The requested number of sessions is in excess of guideline recommendations for 6 visit clinical trial, and it is also in excess of chronic sprain recommendations. As such, the request for Six (6) physical therapy 2 times per week for 3 weeks for left shoulder is not medically necessary.