

<b>Case Number:</b>	CM15-0087653		
<b>Date Assigned:</b>	05/11/2015	<b>Date of Injury:</b>	03/08/2012
<b>Decision Date:</b>	06/11/2015	<b>UR Denial Date:</b>	05/01/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	05/07/2015

### 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: Maryland

Certification(s)/Specialty: Physical Medicine & Rehabilitation, Neuromuscular 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 45-year-old, female who sustained a work related injury on 3/8/12. The diagnoses have included right hand cyst, right thumb de Quervain's tenosynovitis, cervical spine herniated nucleus pulposus, cervical myofascial pain syndrome and bilateral thoracic outlet syndrome, right greater than left. The treatments have included acupuncture, medicated topical cream and oral medications. In the PR-2 dated 12/16/14, the injured worker complains of burning cervical spine pain. She rates this pain level at 10/10. She complains of dull, radiating pain in right shoulder. She rates this pain level a 10/10. She also complains of dull, tingling pain in right wrist/fingers. She has had no functional improvement since last visit. The treatment plan includes a recommendation for physical therapy.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Physical therapy (2x6) on the right upper extremities (right shoulder/hand/wrist): Upheld**

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

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

**Decision rationale:** Physical therapy (2x6) on the right upper extremities (right shoulder/hand/wrist) is not medically necessary per the MTUS Chronic Pain Medical Treatment Guidelines. The MTUS recommends up to 10 visits for this condition. The documentation indicates that the patient has had prior PT therefore should be competent in a home exercise program. It is unclear why the patient would require 12 more supervised therapy visits. The request for physical therapy is not medically necessary.