

<b>Case Number:</b>	CM14-0129100		
<b>Date Assigned:</b>	08/18/2014	<b>Date of Injury:</b>	02/15/2008
<b>Decision Date:</b>	10/07/2014	<b>UR Denial Date:</b>	07/14/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	08/13/2014

### 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. The expert reviewer is Board Certified in Physical Medicine and Rehabilitation and is licensed to practice in Florida and New York 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

### 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 42-year-old female with a reported date of injury on February 15, 2008. The mechanism of injury is described as the injured worker assisting with lifting an ambulance gurney containing a 400-pound patient from a low position to 2 feet. The primary diagnosis is Carpal Tunnel Syndrome (354.0). Bilateral upper extremity diagnostic study (EMG/NCV) dated June 11, 2014 was grossly normal. The encounter note further documented the electrodiagnsotic study did not reveal any evidence of cervical radiculopathy, focal neuropathy, nor polyneuropathy. The injured worker was noted to be permanent and stationary. Work restrictions included no lifting greater than ten pounds and no repetitive or forceful activities using the right upper extremity. Treatments have included hand therapy, surgery, cognitive behavioral therapy, home exercise program, and medications. A follow-up visit note dated July 02, 2014 demonstrates complaints of right upper extremity pain to the dorsal aspect of forearm and wrist. Numbness to light touch was noted along the volar ulnar aspect of the right hand. The injured worker noted decreased use of the right shoulder due to lower extremity pain. Range of motion of the right shoulder was decreased on physical exam. A prior utilization review determination resulted in denial of physical therapy one time per week for six weeks, right shoulder, right elbow, and right wrist on July 14, 2014.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Physical Therapy One (1) Time Per Week For Six (6) Weeks, Right Shoulder, Right Elbow and Right Wrist: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medical Guidelines Page(s): 99. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Shoulder, Elbow, Forearm, Wrist, and Hand

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

**Decision rationale:** This individual already has received an extensive amount of physical therapy and twenty sessions of a functional restoration program. It is unclear why the claimant is unable to perform a self-directed home exercise program under medical supervision. Therefore, the request is not medically necessary.