

<b>Case Number:</b>	CM14-0144628		
<b>Date Assigned:</b>	09/12/2014	<b>Date of Injury:</b>	06/16/2004
<b>Decision Date:</b>	10/14/2014	<b>UR Denial Date:</b>	09/03/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	09/06/2014

### 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, has a subspecialty in Interventional Spine and is licensed to practice in California. 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 patient is a 38-year-old female with a date of injury of 06/16/2004. The current diagnosis include status post left dorsal wrist ganglion incision and triangular fibrocartilage repair; status post left shoulder rotator cuff repair, 01/26/2009; status post right shoulder arthroscopic subacromion decompression, 08/07/2012; complaints of depression, anxiety; and sleep issues and lateral epicondylitis, right elbow. According to progress report 08/15/2014, the patient presents with ongoing left wrist and hand pain with numbness, tingling, weakness, stiffness, and trembling. Examination revealed healed right arthroscopic portals with decreased range of motion in forward flexion and abduction. Examination of the right elbow revealed positive tender medial and posterior. Examination of the hand revealed decreased sensation to light touch at the volar wrist. Treater is requesting 12 additional sessions of physical therapy for the bilateral upper extremities. Utilization Review denied the request on 09/13/2014.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Physical Therapy 2 x week x 6 weeks:** Upheld

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

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

**Decision rationale:** This patient presents with ongoing left wrist/hand pain with numbness, tingling, weakness, stiffness, and trembling. The treater is requesting additional physical therapy 2 times a week for 6 weeks as the patient continues with symptoms. For physical medicine, the MTUS Guidelines page 98 and 99 recommends for myositis, myalgia, and neuritis type symptoms, 9 to 10 sessions over 8 weeks. Review of the medical file indicates the patient underwent 12 physical therapy sessions for the upper extremities between 05/08/2014 and 06/26/2014. In this case, the treater's request for additional 12 sessions exceeds what is recommended by MTUS. Furthermore, the treater does not discuss why the patient would not be able to transition into a home exercise program. Therefore, this request is not medically necessary.