

<b>Case Number:</b>	CM15-0063574		
<b>Date Assigned:</b>	04/09/2015	<b>Date of Injury:</b>	10/14/2012
<b>Decision Date:</b>	05/08/2015	<b>UR Denial Date:</b>	04/02/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	04/03/2015

### 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

Certification(s)/Specialty: Emergency 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 10/14/2012. She reported an initial injury including a right arm fracture, treated with ORIF in 2003 and additional surgery to the shoulder and wrist. That event was followed by a consequence injury involving numbness and tingling to bilateral upper extremities and cervical spine on 10/14/12. Diagnoses include chronic cervicgia, chronic right shoulder pain, and bilateral carpal tunnel syndrome. Treatments to date include activity modification, rest, braces, and chiropractic treatments. Currently, she complained of left upper extremity complaints. On 3/23/15, the physical examination documented palpable guarding along cervical spine, upper trapezius and parascapular muscles, left greater than right. The plan of care included physical therapy to treat the left upper extremity.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Eight sessions of physical therapy for the left upper extremity:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 264-265. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Forearm, Wrist and Hand (Acute & Chronic), Physical Therapy.

**Decision rationale:** The requested eight sessions of physical therapy for the left upper extremity, is not medically necessary. American College of Occupational and Environmental Medicine (ACOEM), 2nd Edition, (2004), Chapter 11, Forearm, Wrist and Hand Complaints, Physical Methods, Pages 264-265 and Official Disability Guidelines (ODG), Forearm, Wrist and Hand (Acute & Chronic), Physical Therapy, recommend continued physical therapy with documented objective evidence of derived functional improvement from completed physical therapy sessions as a transition to a dynamic home exercise program. The injured worker has left upper extremity pain. The treating physician has documented palpable guarding along cervical spine, upper trapezius and parascapular muscles, left greater than right. The treating physician has not documented the medical necessity for therapy sessions beyond a trial of 6 sessions and re-evaluation. The criteria noted above not having been met, eight sessions of physical therapy for the left upper extremity is not medically necessary.