Case Number:	CM17-0012517		
Date Assigned:	01/24/2017	**Date of Injury:**	10/21/2016
Decision Date:	02/17/2017	**UR Denial Date:**	12/19/2016
Priority:	Standard	**Application Received:**	01/18/2017

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, Montana, 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 33 year old female who sustained a work related injury on October 21, 2016, incurring neck, right shoulder and right hand and wrist injuries. She was diagnosed with a shoulder strain, and impingement syndrome, right wrist and right hand sprain and wrist tendinitis and bursitis. Treatment included an unknown amount of physical therapy, pain medications, and activity modifications. Currently, the injured worker complained of ongoing neck pain and stiffness. The pain radiated to both shoulders and upper extremities and into the hands and fingers with numbness and tingling. Her pain was aggravated with tilting her head up and down and sided to side. The pain increased with prolonged sitting and standing. She had difficulty sleeping due to the persistent pain. She rated the pain 7-8 out of 10 on a pain scale from 0 to 10. She had popping and clicking into the right shoulder with increased pain with above the shoulder reaching and lifting. The injured worker had ongoing pain into the wrist and hand with gripping, grasping, pushing and pulling and repetitive hand and finger movements. She noted difficulty performing her activities of daily living and self-care and hygiene. The treatment requested for review included twelve sessions of physical therapy for the right shoulder, right wrist and right hand. On December 19, 2016, a request for twelve sessions of physical therapy for the right shoulder, right wrist and right hand was denied by utilization review.

IMR ISSUES, DECISIONS AND RATIONALES

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

Twelve sessions of physical therapy for the right shoulder, right wrist and right hand, three times a week for four weeks: Upheld

Claims Administrator guideline: Decision based on MTUS Shoulder Complaints 2004, Section(s): Initial Care, and Forearm, Wrist, and Hand Complaints 2004, Section(s): Initial Care. Decision based on Non-MTUS Citation Official Disability Guidelines, Shoulder Chapter, Hand Chapter, Physical therapy.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2016, Section(s): Physical medicine treatment. 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." At the conclusion of this trial, additional treatment would be assessed based upon documented objective, functional improvement, and appropriate goals for the additional treatment. ODG specifies: "Rotator cuff syndrome/Impingement syndrome: Medical treatment: 10 visits over 8 weeks. Post-injection treatment: 1-2 visits over 1 week Post-surgical treatment, arthroscopic: 24 visits over 14 weeks. Post-surgical treatment, open: 30 visits over 18 weeks." Submitted medical records document the patient was approved for 8 therapy sessions on 10-19-16. Additional treatment is based upon documented objective, functional improvement, and appropriate goals. Therapy outcome was not included for review. As such, the request for Twelve sessions of physical therapy for the right shoulder, right wrist and right hand, three times a week for four weeks is not medically necessary.