

<b>Case Number:</b>	CM13-0031846		
<b>Date Assigned:</b>	12/04/2013	<b>Date of Injury:</b>	10/13/2006
<b>Decision Date:</b>	01/24/2014	<b>UR Denial Date:</b>	09/18/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/04/2013

### HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Physical Medicine & Rehabilitation 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 physician 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 65-year-old female with a reported date of injury on 10/13/2006. The patient presented with neck pain, left shoulder pain, left wrist pain radiating into the first 3 fingers, left buttock pain, lateral hip pain, and low back pain. There was a positive Phalen's sign on the left, positive Tinel's sign over the left median nerve in the carpal tunnel, tenderness over the left greater trochanter/trochanteric bursa, tenderness in the paravertebral at the levels of L4-5, L5-S1 bilaterally, and weakness in the left wrist. The patient had diagnoses including myofascial pain syndrome, carpal tunnel syndrome, left trochanteric bursitis. The physician's treatment plan included a request for physical therapy 3x6, low back, left shoulder, and left wrist.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Physical therapy 3 x 6, low back, left shoulder and left wrist:** Upheld

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

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

**Decision rationale:** The California MTUS guidelines note active therapy is based on the philosophy that therapeutic exercise and/or activity are beneficial for restoring flexibility,

strength, endurance, function, range of motion, and can alleviate discomfort. Active therapy requires an internal effort by the individual to complete a specific exercise or task. This form of therapy may require supervision from a therapist or medical provider such as verbal, visual and/or tactile instruction(s). Allow for fading of treatment frequency (from up to 3 visits per week to 1 or less), plus active self-directed home Physical Medicine. The guidelines recommend 8-10 sessions of physical therapy over 4 weeks. The guidelines also recommend patients should undergo a 6 session trial of physical therapy followed by a complete assessment of the patient's condition in order to assess functional improvement before continuing therapy. Within the provided documentation, the requesting physician did not include a recent complete assessment of the patient's objective functional condition in order to demonstrate deficits needing to be addressed with physical therapy. It was unclear within the provided documentation if the patient attended physical therapy in the past as well as the efficacy of any past physical therapy treatments. Additionally, the request for 18 sessions of physical therapy would exceed the guideline recommendations. Therefore, the request for physical therapy 3x6, low back, left shoulder, and left wrist is neither medically necessary nor appropriate.