

<b>Case Number:</b>	CM13-0051565		
<b>Date Assigned:</b>	12/27/2013	<b>Date of Injury:</b>	04/16/2012
<b>Decision Date:</b>	05/09/2014	<b>UR Denial Date:</b>	10/30/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	11/14/2013

### 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 Anesthesiology, a subspecialty in Pain Medicine and is licensed to practice in Texas and Florida. 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 was injured on 4/16/2012. The diagnosis was left upper extremity pain. There is a past medical history of right rotator cuff injury. On 7/20/2012, [REDACTED], an Orthopedic and Hand specialist noted subjective complaints of occasional injury related pain but did not document any objective physical findings. There was normal sensory and motor function of the left upper extremity. The patient requested to be discharged from care. On 10/21/2013, [REDACTED]. [REDACTED] did not document any objective findings indicating residual left upper extremity dysfunction. The patient reported that the pain was relieved by heat and rest. A Utilization Review was rendered on 10/30/2013 recommending non certification for PT three times a week for two years

### IMR ISSUES, DECISIONS AND RATIONALES

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

**PHYSICAL THERAPY THREE (3) TIMES A WEEK FOR TWO (2) YEARS FOR THE LEFT HAND & ARM:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 98-99.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 46-49, 98-99.

**Decision rationale:** The Expert Reviewer's decision rationale: The CA MTUS addressed the use of physical therapy in the management of chronic musculoskeletal pain. It is recommended that physical therapy can be incorporative in the management of acute post surgical or chronic pain that did not respond to NSAIDs or local measures such as ice and heat therapy. It is necessary to do periodic evaluation of effectiveness of the physical therapy program before the recommended 6-12 weeks of therapy could be extended. The available medical records indicate that the symptoms from the left upper extremity injury had resolved by 7/20/2012. The records did not indicate that the patient is currently being managed with NSAIDs. The lack of subjective and objective symptoms did not meet the criteria for physical therapy treatment