

<b>Case Number:</b>	CM14-0010740		
<b>Date Assigned:</b>	02/21/2014	<b>Date of Injury:</b>	08/22/2003
<b>Decision Date:</b>	06/30/2014	<b>UR Denial Date:</b>	12/23/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	01/27/2014

### 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 Internal Medicine, 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 injured worker is a 57 year old female whose date of injury is 08/22/2003. The mechanism of injury is described as pushing a heavy tool. Progress note dated 11/19/13 indicates that she is having neck pain and bilateral upper extremity pain. Diagnoses are cervical spine sprain/strain, cervical spondylosis and neural foraminal narrowing, status post right shoulder arthroscopy, status post left shoulder arthroscopy, status post bilateral lateral epicondylar release, status post bilateral carpal tunnel release, and status post exploration of right biceps tendon. Progress report dated 02/11/14 indicates that there is pain at extremes of motion to the bilateral shoulders. Bilateral elbows show full range of motion.

### IMR ISSUES, DECISIONS AND RATIONALES

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

#### **PHYSICAL THERAPY 8 VISITS TO BILATERAL UPPER EXTREMITIES:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation MTUS: CHRONIC PAIN MEDICAL TREATMENT GUIDELINES, CALIFORNIA CODE OF REGULATIONS, TITLE 8, EFFECTIVE JULY 18, 2009., ,

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines MANUAL THERAPY AND MANIPULATION Page(s): 58-60.

**Decision rationale:** Based on the clinical information provided, the request for physical therapy 8 visits to bilateral upper extremities is not recommended as medically necessary. The injured worker is noted to be status post multiple surgeries; however, no operative reports were submitted for review, and there is no comprehensive assessment of postoperative treatment completed to date or the injured worker's response thereto submitted for review. There is no current, detailed physical examination submitted for review and no specific, time-limited treatment goals are provided. CA MTUS guidelines would support 1-2 visits every 4-6 months for recurrence/flare-up and note that elective/maintenance care is not medically necessary.