

<b>Case Number:</b>	CM14-0017510		
<b>Date Assigned:</b>	04/18/2014	<b>Date of Injury:</b>	03/19/2012
<b>Decision Date:</b>	06/03/2014	<b>UR Denial Date:</b>	01/31/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	02/12/2014

### 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 Occupational 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 patient has submitted a claim for bilateral carpal tunnel syndrome, cervicothoracic sprain/strain, lumbar spine sprain/strain, and left leg radiculopathy associated with an industrial injury date of 03/19/2012. The treatment to date has included physical therapy x 12 visits, chiropractic care, home exercise program, right wrist open carpal tunnel release on 08/28/2013, electrical stimulation unit, and medications. The utilization review from 01/31/2014 denied the request for physical therapy 12 sessions (right shoulder) because of lack of documentation regarding a recent exacerbation that will require additional therapy visits. The medical records from 2013 to 2014 were reviewed showing that patient complained of worsening symptoms of headache, and pain at the neck, bilateral shoulder, bilateral wrist/hand, and low back. The pain radiated into the bilateral upper extremities. Physical examination showed tenderness at bilateral trapezius, anterior/lateral aspects of bilateral shoulder, volar aspect of bilateral wrist, medial joint line of bilateral knees, and left lumbosacral and midline area of lumbar spine. Range of motion was limited with presence of pain at the cervical spine, bilateral shoulders, bilateral wrists, and lumbar spine. Neer and Hawkin's tests were positive bilaterally.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**12 SESSIONS OF PHYSICAL THERAPY ON RIGHT THE SHOULDER:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints, Chapter 12 Low Back Complaints Page(s): 204, 299. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Physical Therapy Guidelines.

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

**Decision rationale:** As stated in the California MTUS Chronic Pain Medical Treatment Guidelines, physical medicine is recommended and that given frequency should be tapered and transition into a self-directed home program. In this case, the patient already completed 12 sessions of physical therapy. The rationale given for this request is because of worsening shoulder pain. However, medical records submitted for review do not include a comprehensive physical examination of the right shoulder, i.e. sensorimotor findings, as well as limitation in activities of daily living caused by the right shoulder pain. Furthermore, the patient is expected to be well-versed on performing independent exercises by now. Therefore, the request for twelve sessions of physical therapy on the right shoulder is not medically necessary.