

<b>Case Number:</b>	CM14-0082495		
<b>Date Assigned:</b>	07/21/2014	<b>Date of Injury:</b>	02/18/2011
<b>Decision Date:</b>	08/26/2014	<b>UR Denial Date:</b>	05/28/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	06/04/2014

### 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 Physical Medicine & Rehabilitation, has a subspecialty in Interventional Spine, 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 is a 53 year old female with an injury date on 02/18/2011. Based on the 05/12/2014 progress report provided by [REDACTED], the diagnoses are: 1. Chronic left shoulder impingement syndrome. 2. Chronic left lumbar radiculopathy. According to this report, the patient complains of chronic left shoulder and low back pain. There is full active range of motion of both shoulders. There is a decreased active range of motion of the lumbar spine in all planes. Tenderness to palpation of the left anterior shoulder and the acromioclavicular joint was noted. The straight leg raise positive bilateral. Hawkins and Apley's scratch tests are mildly positive on the left. There were no other significant findings noted on this report. [REDACTED] is requesting physical therapy 2 times a week for 3 weeks for the left shoulder and lumbar spine. The utilization review denied the request on 05/28/2014. [REDACTED] is the requesting provider, and he provided treatment reports from 05/12/2014 to 06/16/2014.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**PT(Physical Therapy) 2 x 3 (6) for the left shoulder and lumbar spine: Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine, Physical Medicine Guidelines - Reflex sympathetic dystrophy (CRPS Page(s): 98-99.

**Decision rationale:** According to the 05/12/2014 report by [REDACTED] this patient presents with chronic left shoulder and low back pain. The treater is requesting 6 sessions of physical therapy for the left shoulder and lumbar spine. The UR denial letter states "it is not clear that she is having a significant exacerbation or flare-up of symptoms above her baseline to warrant re-initiation of physical therapy at this juncture." For physical medicine, the MTUS guidelines recommend for myalgia and myositis type symptoms 9-10 visits over 8 weeks. Review of available reports show no therapy reports were provided and there is no discussion regarding the patient's progress on any of the reports. In this case, if the patient did not have any recent therapy, a short course of therapy may be reasonable if the patient's symptoms are flared, or for significant decline in function but the treater does not discuss what is to be achieved with additional therapy. The patient has full active range of motion of both shoulders. No discussion is provided as to why the patient is not able to perform the necessary home exercises. The request is not medically necessary.

**TENS unit pads refill (quantity unspecified):** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines TENS, chronic pain (transcutaneous electrical nerve stimulation).

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 8.

**Decision rationale:** According to the 05/12/2014 report by [REDACTED] this patient presents with chronic left shoulder and low back pain. The treater is requesting TENS unit pads refill (quantity unspecified). The MTUS guidelines require that the treater monitor the patient's treatments and provide appropriate recommendations. In this case, the treater does not discuss how often the patient is using TENS unit and with what benefit. The request also lacks the specific quantity of pads. The request is not medically necessary.