

<b>Case Number:</b>	CM14-0124543		
<b>Date Assigned:</b>	08/08/2014	<b>Date of Injury:</b>	09/23/2013
<b>Decision Date:</b>	03/18/2015	<b>UR Denial Date:</b>	07/25/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	08/06/2014

### 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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:

State(s) of Licensure: New York

Certification(s)/Specialty: Internal Medicine

### 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 61 year old male patient, who sustained an industrial injury on 09/23/2013. An orthopedic consultation visit dated 12/10/2014 reported with ongoing issue of his lumbar spine with current complaint of ongoing neck, bilateral shoulder and both upper and lower back pains. Additionally, he complains of symptom into his hips, buttocks and ankles bilaterally and some memory loss. Physical examination found his standing posture showed some mild thoracic kyphosis with more of a flat lumbar region. The range of motion of his spine is markedly limited. He has downgoing Babinski. the orthopedic recommendation stated that he become permanent and stationary and be gien permanent disability; not to return to this occupation. On 07/25/2014 Utilization Review non-certified a request for additional physical therapy session treating the left shoulder,noting the CA MTUS Post-Surgical Guidelines were cited. the injured worker submitted an application for independent medical review of services.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Additional Physical therapy, left shoulder 2x6:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Postsurgical Treatment Guidelines Page(s): 27.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Physical Therapy Page(s): 98 ( pdf format).

**Decision rationale:** Per California MTUS Treatment Guidelines 2009, physical therapy is indicated for the treatment of musculoskeletal conditions. Recommendations state that for most patients with more severe acute and subacute pain conditions physical therapy is indicated as long as functional improvement and program progression are documented. 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. Patients are instructed and expected to continue active therapies at home as an extension of the treatment process in order to maintain improvement levels. Home exercise can include exercise with or without mechanical assistance or resistance and functional activities with assistive devices. In this case the claimant has completed 24 sessions of physical therapy and per the documentation has 75-80% of his normal range of motion. There is no specific indication for continued physical therapy sessions. Medical necessity for the requested service has not been established. The requested service is not medically necessary.