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| <b>Case Number:</b>   | CM15-0100691 |                              |            |
| <b>Date Assigned:</b> | 06/05/2015   | <b>Date of Injury:</b>       | 06/10/2006 |
| <b>Decision Date:</b> | 07/09/2015   | <b>UR Denial Date:</b>       | 05/07/2015 |
| <b>Priority:</b>      | Standard     | <b>Application Received:</b> | 05/26/2015 |

### 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: California

Certification(s)/Specialty: Physical Medicine & Rehabilitation, Pain Management

### 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 40 year old male, who sustained an industrial injury on 06/10/2006. He has reported subsequent neck, back, shoulder, gluteal, upper and lower extremity pain and was diagnosed with cervicgia, lumbago, chronic pain, cervical and lumbosacral spondylosis, myalgia and myositis and spondylolisthesis. Treatment to date has included oral and injectable pain medication, physical therapy, surgery and application of heat and ice. In a progress note dated 05/04/2015, the injured worker complained of back, gluteal, neck and bilateral lower extremity pain. Objective findings were notable for tenderness and pain with range of motion of the cervical spine, lumbar spine and left shoulder. A request for authorization of occupational therapy of the left shoulder was submitted. A therapy report dated April 13, 2015 indicates that the patient has completed 10 out of 12 therapy sessions. Range of motion is full with improving strength and no pain.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Occupational Therapy Left Shoulder 2x4:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 200. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Shoulder Chapter, Physical Therapy.

**Decision rationale:** Regarding the request for additional physical therapy, Chronic Pain Medical Treatment Guidelines recommend a short course of active therapy with continuation of active therapies at home as an extension of the treatment process in order to maintain improvement levels. ODG has more specific criteria for the ongoing use of physical therapy. ODG recommends a trial of physical therapy. If the trial of physical therapy results in objective functional improvement, as well as ongoing objective treatment goals, then additional therapy may be considered. Within the documentation available for review, there is documentation of completion of prior PT sessions, but there is no documentation of specific objective functional improvement with the previous sessions and remaining deficits that cannot be addressed within the context of an independent home exercise program, yet are expected to improve with formal supervised therapy. In light of the above issues, the currently requested additional physical therapy is not medically necessary.