

<b>Case Number:</b>	CM15-0101445		
<b>Date Assigned:</b>	06/03/2015	<b>Date of Injury:</b>	05/23/2013
<b>Decision Date:</b>	07/02/2015	<b>UR Denial Date:</b>	05/20/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	05/27/2015

### 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

### 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 60 year old male, who sustained an industrial injury on May 23, 2014. He reported neck pain and bilateral shoulder pain. The injured worker was diagnosed as having status post right shoulder arthroscopic procedure, cervical spine strain/sprain, left shoulder sprain/strain and carpal tunnel syndrome. Treatment to date has included diagnostic studies, radiographic imaging, surgical intervention of the right shoulder, conservative therapies, medications and work restrictions. Currently, the injured worker complains of continued neck pain and bilateral shoulder pain. The injured worker reported an industrial injury in 2014, resulting in the above noted pain. He was treated conservatively and surgically without complete resolution of the pain. Evaluation on February 10, 2015, revealed continued pain as noted. Evaluation on March 30, 2015, revealed continued pain as noted. He reported increasing left compensatory shoulder pain. It was noted surgical intervention may be required for the worsening left shoulder pain. Physical therapy and medications were requested.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Physical therapy 2 times a week for 3 weeks:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Guidelines Page(s): 98-99.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Physical Therapy, pages 98-99.

**Decision rationale:** Physical therapy is considered medically necessary when the services require the judgment, knowledge, and skills of a qualified physical therapist due to the complexity and sophistication of the therapy and the physical condition of the patient. However, there is no clear measurable evidence of progress with the PT treatment already rendered including milestones of increased ROM, strength, and functional capacity. Review of submitted physician reports show no evidence of functional benefit, unchanged chronic symptom complaints, clinical findings, and functional status. There is no evidence documenting functional baseline with clear goals to be reached and the patient striving to reach those goals. The Chronic Pain Guidelines allow for visits of physical therapy with fading of treatment to an independent self-directed home program. It appears the employee has received significant therapy sessions without demonstrated evidence of functional improvement to allow for additional therapy treatments. There is no report of acute flare-up, new injuries, or change in symptom or clinical findings to support for formal PT in a patient that has been instructed on a home exercise program for this chronic injury. Submitted reports have not adequately demonstrated the indication to support further physical therapy when prior treatment rendered has not resulted in any functional benefit. The Physical therapy 2 times a week for 3 weeks is not medically necessary and appropriate.

**Refill of Anaprox #60:** Overturned

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs (non-steroidal anti-inflammatory drugs) Page(s): 67, 68, 73.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs (non-steroidal anti-inflammatory drugs), page 22.

**Decision rationale:** Anti-inflammatories are the traditional first line of treatment, to reduce pain so activity and functional restoration can resume, but long-term use may not be warranted. Monitoring of the NSAID's functional benefit is advised as long term use of NSAIDS beyond a few weeks may actually retard muscle and connective tissue healing. At this time, the patient continues to have pain relief to oral NSAID to support its continued use. The Refill of Anaprox #60 is medically necessary and appropriate.