

<b>Case Number:</b>	CM15-0130062		
<b>Date Assigned:</b>	07/16/2015	<b>Date of Injury:</b>	05/14/2004
<b>Decision Date:</b>	08/12/2015	<b>UR Denial Date:</b>	06/26/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	07/06/2015

### 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: Massachusetts

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 50 year old female, who sustained an industrial injury on May 14, 2004. The initial symptoms reported by the injured worker are unknown. The injured worker was diagnosed as having displacement of cervical intervertebral disc without myelopathy, degeneration of cervical intervertebral disc and carpal tunnel syndrome. Treatment to date has included diagnostic studies and medications. On November 19, 2014, the injured worker complained of neck pain. Much of the handwritten report was illegible. The treatment plan included a cervical injection. A more current treatment plan dated December 18, 2014, contained no subjective complaints. The handwritten treatment plan is mostly illegible. On June 26, 2015, Utilization Review non-certified the request for right shoulder physical therapy two times a week for six weeks, citing California MTUS Guidelines.

### 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 6 weeks for the right shoulder:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) (1) Chronic pain, Physical medicine treatment. (2) Preface, Physical Therapy Guidelines.

**Decision rationale:** The claimant has a remote history of a work-related injury and is being treated for neck and left shoulder pain. An MRI of the left shoulder in April 2015 included findings of partial rotator cuff tears and bursitis. When seen, there were trapezius and rhomboid muscle spasms with decreased lumbar range of motion. Authorization for physical therapy was requested. The claimant is being treated for chronic pain with no new injury. In terms of physical therapy treatment for chronic pain, guidelines recommend a six visit clinical trial with a formal reassessment prior to continuing therapy. In this case, the number of visits requested is in excess of that recommended or what might be needed to determine whether further physical therapy was likely to be effective. The request is not medically necessary.