

<b>Case Number:</b>	CM15-0140529		
<b>Date Assigned:</b>	07/30/2015	<b>Date of Injury:</b>	11/06/2002
<b>Decision Date:</b>	08/27/2015	<b>UR Denial Date:</b>	06/24/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	07/20/2015

### 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 57 year old female, who sustained an industrial injury on 11-6-02. The injured worker has complaints of low back pain. Lumbar spine examination revealed tenderness about the left sided lower lumbar paravertebral musculature. The diagnoses have included cervical myofascial pain and chronic pain syndrome. Treatment to date has included tramadol and electromyography/nerve conduction study in November 2014 showed chronic right L5 (or L4) radiculopathy and chronic left L4 radiculopathy. The request was for physical therapy 3 times a week for 4 weeks for the right shoulder.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Physical therapy 3 times a week for 4 weeks for the right shoulder:** Upheld

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

**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 sustained a work-related injury in November 2002 and is being treated for right shoulder pain. When seen, there was right shoulder anterolateral tenderness with decreased range of motion and positive impingement testing with normal strength. A cortisone injection was declined. 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 continuation of physical therapy was likely to be effective. The request was not medically necessary.