

<b>Case Number:</b>	CM15-0143806		
<b>Date Assigned:</b>	08/04/2015	<b>Date of Injury:</b>	06/02/2014
<b>Decision Date:</b>	09/23/2015	<b>UR Denial Date:</b>	07/08/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	07/24/2015

### 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 51-year-old female who sustained an industrial injury on June 02, 2014. The initial report of illness dated March 11, 2015 reported the accident occurring from repetitive movements resulting in injury to the cervical spine, lumbar spine and bilateral hands. The worker was diagnosed with having right hand strain and sprain rule out tendinitis, carpal tunnel syndrome; left hand strain and sprain rule out tendinitis, carpal tunnel syndrome; cervical strain and sprain rule out radiculitis or radiculopathy, secondary to cervical herniated disc, and lumbar spine strain and sprain rule out radiculitis and radiculopathy secondary to herniated disc. The worker was temporarily totally disabled for 6 weeks. A primary treating office visit dated January 15, 2015 reported unchanged anxiety, abdominal pain, depression, sleep quality, dizziness, headaches, nausea or vomiting, visual disturbances of chronic musculoskeletal pain of neck, bilateral wrists, forearms, elbows and upper back. She states having undergone nerve conduction study of the right arm wrist, hand on January 12, 2015, and is currently taking Tylenol ES. She was diagnosed with the following: right hand weakness; lumbar strain and sprain; numbness to bilateral arms and hands; bilateral hand strain; cervical strain and sprain and thoracic sprain and strain. There is recommendation to undergo a magnetic resonance imaging study of both cervical and lumbar spine. She is to receive chiropractic care and the following medications: Tramadol, and Tylenol ES. She is advised to discontinue the use of Tizanidine and any NSAIDs due to gastritis. Treating diagnoses listed at follow up February 12, 2015 were: right hand weakness with moderate sensorimotor median neuropathy across the bilateral wrists, greater on the right; lumbar strain and sprain; numbness bilateral hands and arms; bilateral hand

strain; cervical strain and sprain and thoracic sprain and strain. At a primary treating office visit dated March 11, 2105 the plan of care noted recommendation for an electric nerve conduction study be performed, an magnetic resonance imaging study of cervical spine, interferential unit for home use; lumbar spine orthotic brace; and prescribed a course of physical therapy treating cervical , lumbar and bilateral hands. The following medications noted prescribed: Anaprox, Ultram, and Prilosec. Notes indicate the physical therapy was previously prescribed.

### **IMR ISSUES, DECISIONS AND RATIONALES**

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

**Physical Therapy, Right Shoulder, 3 times wkly for 4 wks, 12 sessions: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine.

**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. If the patient has not undergone physical therapy previously, the current request exceeds the amount recommended as a trial by guidelines. In light of the above issues, the currently requested additional physical therapy is not medically necessary.