

<b>Case Number:</b>	CM15-0190877		
<b>Date Assigned:</b>	10/05/2015	<b>Date of Injury:</b>	06/08/2011
<b>Decision Date:</b>	11/10/2015	<b>UR Denial Date:</b>	09/22/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	09/28/2015

### 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 45 year old female, who sustained an industrial injury on 06-08-2011. She has reported subsequent neck, back, shoulder, elbow and wrist pain and was diagnosed with left shoulder impingement, sprain, strain and rotator cuff injury, right wrist tendinitis, cervical disc disease, cervical radiculopathy, bilateral shoulder internal derangement, status post bilateral carpal tunnel release, right lateral epicondylitis. MRI of the cervical spine in April 2013 was noted to show posterior annular tear and 3 mm disc protrusion at C5-C6 with neuroforaminal stenosis and 2.5 mm disc protrusion at C6-C7 with bilateral neuroforaminal narrowing. Treatment to date has included pain medication, physical therapy, cervical epidural steroid injection, acupuncture and surgery. Acupuncture was noted to have worsened left shoulder and neck pain. Pain medication provided some relief of pain. The injured worker was noted to have had 12 physical therapy sessions authorized in 2013 and to have completed at least 8 sessions with decrease in pain although the degree of relief was not quantified. There was no documentation of specific objective functional improvement with therapy. In a progress note dated 09-03-2015, the injured worker reported flare up of mid back, left shoulder, left elbow and left wrist pain with locking of the left thumb. Objective examination findings revealed tenderness to palpation of the left shoulder, left elbow and left wrist, decreased range of motion of the left shoulder, positive Cozen's and Tinel's sign of the left elbow, tenderness to palpation of the thoracic paravertebral muscles and rhomboids and decreased range of motion of the thoracic spine. Work status was documented as temporarily totally disabled due to flare-up of pain. A

request for authorization of PT 8 sessions 2x4, shoulder exercise kit was submitted. As per the 09-22-2015 utilization review, the requests for PT and shoulder exercise kit were non-certified.

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

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

#### **PT 8 Sessions 2x4: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Physical Medicine.

**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 PT 8 Sessions 2x4 is not medically necessary and appropriate.

#### **Shoulder Exercise Kit: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Exercise.

**Decision rationale:** Although the MTUS guidelines do recommend daily exercises, submitted reports have not demonstrated any evidence to support the medical necessity for a home exercise kit versus simple inexpensive resistive therabands to perform isometrics and eccentric exercises. Exercise equipment is considered not primarily medical in nature and could withstand repeated use as rental or used by successive patients which is not indicated here. The patient continues to participate in active physical therapy and should have received instructions for an independent home exercise program without the need for specialized equipment. The Exercise Kit is not medically necessary and appropriate.