

<b>Case Number:</b>	CM15-0204340		
<b>Date Assigned:</b>	10/21/2015	<b>Date of Injury:</b>	03/25/2011
<b>Decision Date:</b>	12/02/2015	<b>UR Denial Date:</b>	09/21/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/19/2015

### 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 67 year old female, who sustained an industrial injury on 3-25-11. The injured worker was being treated for status post bilateral carpal tunnel releases 2011 with residuals, cervical spine strain with degenerative disc disease, bilateral shoulder subacromial impingement syndrome and rule out intercarpal ligament tear of both wrists. There is history of breast cancer s/p lumpectomy 2012, bilateral mastectomy 2013, and reconstruction 2014. On 8-24-15, the injured worker complains of frequent pain in neck with radiation to shoulders and headaches 4 times a week at back of head (relieved with hot packs and massage), continuous dull pain in neck with radiation to elbow with tightness in left shoulder (relieved with hot packs, massage and analgesic lotion), intermittent dull pain of right shoulder with tightness (relieved with hot packs, massage and analgesic lotion), intermittent dull to sharp pain in left elbow than worsens with increased pain in left hand and wrist (relieved with hot packs, massage and analgesic lotion), intermittent pain in right wrist and dorsum of right hand with swelling of wrist (relieved with hot packs, massage and analgesic lotion), intermittent pain in left wrist and dorsum of left hand with numbness and tingling at fingertips (relieved with hot packs, massage and analgesic lotion and pain in lower back with prolonged sitting and standing. Work status is noted to be retired in 2012 and not working. Physical exam performed on 8-24-15 revealed restricted range of motion of cervical spine, tenderness in bilateral trapezius musculature, normal bilateral shoulder exam with the exception of positive impingement test, tenderness in bilateral wrists with healed bilateral carpal tunnel incisions and slightly diminished light touch in right thumb and index fingers of bilateral hands. X-rays performed on 8-24-15 of c spine and bilateral

shoulders revealed no abnormalities and x-rays of right and left hand revealed degenerative changes of 1st CMC joint. Treatment to date has included Ibuprofen, physical therapy (of neck, shoulders and wrist with no benefit), activity modifications and right and left carpal tunnel release. The treatment plan included request for EMG-NCS of upper extremities, MRI of bilateral shoulders, hands, wrists, ultrasound studies of bilateral shoulders, hands and wrists, physical therapy 2-3 times per week for 6 weeks, occupational therapy 2-3 times a week for 6 weeks and prescriptions for Naproxen 550mg and Omeprazole 20mg. On 9-21-15 request for physical therapy of cervical spine and bilateral shoulders 18 sessions was non-certified by utilization review.

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

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

#### **Physical Therapy for cervical spine: Upheld**

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

**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 previously 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 9-10 visits of physical therapy with fading of treatment to an independent self-directed home program. It appears the employee has received previous therapy sessions without demonstrated evidence of functional improvement to allow for therapy treatment sessions. 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 2011 injury. Submitted reports have not adequately demonstrated the indication to support for the sessions of physical therapy when prior treatment rendered has not resulted in any functional benefit as the patient should continue the independent home exercise program. The Physical Therapy for cervical spine is not medically necessary and appropriate.

#### **Physical Therapy for bilateral shoulders 3x6: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Physical Medicine. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Shoulder Chapter, Physical Therapy Guidelines.

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

**Decision rationale:** Time-limited care plan with specific defined goals, assessment of functional benefit with modification of ongoing treatment based upon the patient's progress in meeting those goals and the provider's continued monitoring of successful outcome is stressed by MTUS guidelines. 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. Submitted reports have no acute flare-up or specific physical limitations to support for physical/ occupational therapy. The Chronic Pain Guidelines allow for 9-10 visits of therapy with fading of treatment to an independent self-directed home program. It is unclear how many PT sessions have been completed; however, the submitted reports have not identified clear specific functional improvement in ADLs, functional status, or decrease in medication and medical utilization nor have there been a change in neurological compromise or red-flag findings demonstrated from the formal physical therapy already rendered to support further treatment. Submitted reports have also not adequately demonstrated the indication to support for excessive quantity of 18 PT sessions without extenuating circumstances established beyond the guidelines. The Physical Therapy for bilateral shoulders 3x6 is not medically necessary and appropriate.