

<b>Case Number:</b>	CM15-0221380		
<b>Date Assigned:</b>	11/16/2015	<b>Date of Injury:</b>	03/26/2012
<b>Decision Date:</b>	12/30/2015	<b>UR Denial Date:</b>	10/29/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	11/10/2015

### 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: Iowa, Illinois, California

Certification(s)/Specialty: Preventive Medicine, Occupational Medicine, Public Health & General Preventive Medicine

### 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 3-26-12. The injured worker was being treated for shoulder impingement, cervical radiculopathy and thoracic sprain. On 8-11-15 the injured worker complained of mild, occasional aching right shoulder pain with numbness in right hand and 10-13-15, the injured worker complains of constant right shoulder pain with intermittent worsening and unchanged from previous visits. She states the symptoms are moderate and she is not taking her Mobic. Work status is noted to be return to full duty. Physical exam on 8-11-15 revealed areas of point tenderness of right shoulder with decreased range of motion and positive impingement sign. Documentation does not include a physical exam on 10-13-15. Treatment to date has included cortisone injection, oral Mobic 15mg (which may have helped), 12 physical therapy visits (without documentation of previous sessions or notation of functional improvement) and home exercise program. The treatment plan included request for physical therapy 1 evaluation and 8 sessions. On 10-29-15 request for 1 physical therapy evaluation and 8 physical therapy 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 1 x 8 Weeks #8, for Right Shoulder: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009. Decision based on Non-MTUS Citation Official Disability Guidelines.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Physical Medicine. Decision based on Non-MTUS Citation Shoulder (Acute & Chronic), Physical Therapy, ODG Preface Physical Therapy.

**Decision rationale:** California MTUS guidelines refer to physical medicine guidelines for physical therapy. Allow for fading of treatment frequency (from up to 3 visits per week to 1 or less), plus active self-directed home Physical Medicine. Regarding physical therapy, ODG states Patients should be formally assessed after a "six-visit clinical trial" to see if the patient is moving in a positive direction, no direction, or a negative direction (prior to continuing with the physical therapy); & (6) When treatment duration and/or number of visits exceeds the guideline, exceptional factors should be noted. At the conclusion of this trial, additional treatment would be assessed based upon documented objective, functional improvement, and appropriate goals for the additional treatment. The request for 8 sessions is in excess of the initial trials per MTUS and ODG guidelines. As such, the request for Physical Therapy 1 x 8 Weeks #8, for Right Shoulder is not medically necessary.

#### **Physical Therapy Evaluation for Cervical Spine, Right Shoulder # 1: Overturned**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009. Decision based on Non-MTUS Citation Official Disability Guidelines.

**MAXIMUS guideline:** Decision based on MTUS Neck and Upper Back Complaints 2004, Section(s): Initial Care, and Chronic Pain Medical Treatment 2009, Section(s): Physical Medicine. Decision based on Non-MTUS Citation Neck and Upper Back, Shoulder (Acute & Chronic), Physical Therapy, ODG Preface Physical Therapy.

**Decision rationale:** MTUS refer to physical medicine guidelines for physical therapy and recommends as follows: Allow for fading of treatment frequency (from up to 3 visits per week to 1 or less), plus active self-directed home Physical Medicine. Additionally, ACOEM guidelines advise against passive modalities by a therapist unless exercises are to be carried out at home by patient. ODG writes regarding neck and upper back physical therapy, Recommended. Low stress aerobic activities and stretching exercises can be initiated at home and supported by a physical therapy provider, to avoid debilitation and further restriction of motion. ODG further quantifies its cervical recommendations with Cervicalgia (neck pain); Cervical spondylosis = 9 visits over 8 weeks Sprains and strains of neck = 10 visits over 8 weeks. Regarding physical therapy, ODG states Patients should be formally assessed after a "six-visit clinical trial" to see if the patient is moving in a positive direction, no direction, or a negative direction (prior to continuing with the physical therapy); & (6) When treatment duration and/or number of visits exceeds the guideline, exceptional factors should be noted. At the conclusion of this trial, additional treatment would be assessed based upon documented objective, functional improvement, and appropriate goals for the additional treatment. Medical records do not indicate any prior physical therapy. Per guidelines, an initial trial of six sessions is necessary before additional sessions can be approved. As such, the request for Physical Therapy Evaluation for Cervical Spine, Right Shoulder # 1 is medically necessary.