

<b>Case Number:</b>	CM15-0057411		
<b>Date Assigned:</b>	04/02/2015	<b>Date of Injury:</b>	06/26/2012
<b>Decision Date:</b>	05/04/2015	<b>UR Denial Date:</b>	02/25/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	03/26/2015

### 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, Hawaii

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 36-year-old female, who sustained an industrial injury on 06/01/2012. The initial complaints or symptoms included progressive left shoulder pain. The initial diagnoses were not mentioned in the clinical notes. Treatment to date has included conservative care, medications, conservative therapies (including physical therapy for the left shoulder and wrist), x-rays, MRIs, nerve conduction studies, cortisone injections, left wrist/hand surgery (08/08/2014), and left shoulder surgery. Currently, the injured worker complains of continued pain and weakness in the left shoulder, pain and spasms in the neck, frequent numbness in the fingers of the left hand and weakness of the left upper extremity. The diagnoses include cervical spine disc bulge, cervical radiculopathy, left shoulder rotator cuff tendinitis, left shoulder impingement syndrome, status post left shoulder subacromial decompression, status post left wrist dorsal ganglion cyst removal, status post trigger finger release of the left thumb and index finger, left carpal tunnel syndrome, and ulnar nerve entrapment at the left elbow. The treatment plan consisted of 12 sessions of physical therapy for the cervical spine, left wrist and left hand, medications, electrodiagnostic testing, and follow-up.

### 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 Cervical Spine: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Postsurgical Treatment Guidelines.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 65-194, Chronic Pain Treatment Guidelines Physical Therapy, Physical Medicine Page(s): 98-99. Decision based on Non-MTUS Citation Neck and Upper Back, 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. The request for 12 sessions is in excess of guidelines. The treating physician does not detail extenuating circumstances that would warrant exception to the guidelines and home exercise program is not sufficient. As such, the request for Physical Therapy 3 times a week for 4 weeks Cervical Spine is not medically necessary.