

<b>Case Number:</b>	CM15-0057495		
<b>Date Assigned:</b>	04/02/2015	<b>Date of Injury:</b>	07/28/2009
<b>Decision Date:</b>	05/29/2015	<b>UR Denial Date:</b>	03/17/2015
<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 40 year old female, who sustained an industrial injury on 7/28/09. The injured worker has complaints of right shoulder pain. The diagnoses have included cervical spine disc bulging with radicular pain; left elbow strain; right shoulder surgery; status post right elbow surgery and left elbow strain. Treatment to date has included motrin; extracorporeal shockwave procedure; right shoulder surgery; status post right elbow surgery; status post right carpal tunnel syndrome surgery; status post left carpal tunnel syndrome surgery and physical therapy. The request was for physical therapy, bilateral upper extremities, 2 times weekly for 6 weeks.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Physical Therapy, Bilateral Upper Extremities, 2 times weekly for 6 weeks:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Physical Therapy, Physical Medicine Page(s): 98-99. Decision based on Non-MTUS Citation Shoulder (Acute & Chronic), Physical Therapy, ODG Preface 1/2 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 medical documentation provided indicates that this patient has attended an unknown number of physical therapy sessions. The treating physician has not provided documentation of objective functional improvement from this previous therapy. As such, the request for Physical Therapy, Bilateral Upper Extremities, 2 times weekly for 6 weeks is not medically necessary.