

<b>Case Number:</b>	CM15-0060899		
<b>Date Assigned:</b>	04/07/2015	<b>Date of Injury:</b>	04/12/2005
<b>Decision Date:</b>	05/06/2015	<b>UR Denial Date:</b>	03/05/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	03/31/2015

### 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: Maryland

Certification(s)/Specialty: Physical Medicine & Rehabilitation, Neuromuscular 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 62 year old male, who sustained an industrial injury on 04/12/2005. The initial complaints and diagnoses were not mentioned in the clinical notes. Treatment to date has included conservative care, medications, injections, MRIs of the left shoulder and lumbar spine. Currently, the injured worker complains of constant moderate left shoulder pain radiating to the left elbow, moderate left wrist and hand pain, and constant moderate to severe low back pain radiating to the knee with numbness and tingling in the feet. The diagnoses include contusion to the left shoulder shoulder/arm sprain, shoulder impingement, wrist sprain, contusion to the wrist, lumbar sprain, non-specific lumbar, thoracic spondylosis without myelopathy, and loss of balance/fall. The treatment plan consisted of 8 sessions of physical therapy for the shoulder, wrist, and lumbar and thoracic spine, and MRI of the left shoulder.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Physical therapy 2 times a week for 4 weeks (8 sessions) shoulder, wrist, lumbar/thoracic spine:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines physical medicine Page(s): 98-99. Decision based on Non-MTUS Citation Official Disability Guidelines (preface).

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Page(s): 98-99.

**Decision rationale:** Physical therapy 2 times a week for 4 weeks (8 sessions) shoulder, wrist, lumbar/thoracic spine is not medically necessary per the MTUS Chronic Pain Medical Treatment Guidelines. The MTUS recommends up to 10 visits for this condition. The documentation indicates that the patient has had a work injury dating back to 2005. It is unclear how much prior therapy for the body parts requested the patient has had and the outcome in terms of objective evidence of functional improvement. Without clarification of this information and rationale why the patient is unable to perform a self-directed home exercise program, the request for additional physical therapy is not medically necessary.