

<b>Case Number:</b>	CM15-0080661		
<b>Date Assigned:</b>	05/01/2015	<b>Date of Injury:</b>	02/08/2013
<b>Decision Date:</b>	06/03/2015	<b>UR Denial Date:</b>	04/20/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	04/27/2015

### 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:

This 52 year old female sustained an industrial injury on 2/8/13. She subsequently reported low back and shoulder pain. Diagnoses include right shoulder impingement, left shoulder rotator cuff tear, low back pain and bilateral carpal tunnel syndrome. Treatments to date include x-ray, nerve conduction and MRI testing, surgery, physical therapy and prescription pain medications. The injured worker continues to experience back, shoulder, bilateral upper extremity and flank pain. Upon examination, left shoulder range of motion was restricted. A request for Physical therapy Re-Evaluation, Back, Left Flank/Shoulder, Bilateral Wrists/Elbow Qty 1 and Additional Physical Therapy for the Back, Left Flank/Shoulder, Bilateral Wrists/Elbow Qty 12 was made by the treating physician.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Physical therapy Re-Evaluation, Back, Left Flank/Shoulder, Bilateral Wrists/Elbow Qty 1: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints, Chapter 12 Low Back Complaints Page(s): 287-315; 260-278, Chronic Pain Treatment Guidelines Physical Therapy, Physical Medicine Page(s): 98-99. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back - Lumbar & Thoracic (Acute & Chronic), Shoulder (Acute & Chronic), Physical Therapy.

**Decision rationale:** California MTUS guidelines 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 quantifies its recommendations with 10 visits over 8 weeks for lumbar sprains/strains and 9 visits over 8 weeks for unspecified backache/lumbago. ODG further states that a "six-visit clinical trial" of physical therapy with documented objective and subjective improvements should occur initially before additional sessions are to be warranted. Medical records indicate this patient is s/p arthroscopic shoulder surgery and the patient has attended an unknown number of post-operative PT sessions. The treating physician has not provided rationale behind the request for re-evaluation or objective functional improvement with previous therapy. As such, the request for Physical therapy Re-Evaluation, Back, Left Flank/Shoulder, Bilateral Wrists/Elbow Qty 1 is not medically necessary.

**Additional Physical Therapy for the Back, Left Flank/Shoulder, Bilateral Wrists/Elbow Qty 12:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints, Chapter 12 Low Back Complaints Page(s): 287-315; 260-278, Chronic Pain Treatment Guidelines Physical Therapy, Physical Medicine Page(s): 98-99. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back - Lumbar & Thoracic (Acute & Chronic), Shoulder (Acute & Chronic), Physical Therapy.

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request for Additional Physical Therapy for the Back, Left Flank/Shoulder,Bilateral  
Wrists/Elbow Qty 12 is not medically necessary.