

<b>Case Number:</b>	CM14-0217000		
<b>Date Assigned:</b>	01/06/2015	<b>Date of Injury:</b>	06/02/2014
<b>Decision Date:</b>	02/28/2015	<b>UR Denial Date:</b>	12/03/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	12/29/2014

### 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: California  
 Certification(s)/Specialty: Physical Medicine & Rehabilitation

### 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 patient is a 37 year old male with the injury date of 06/02/14. Per physician's report 11/18/14, the patient has right shoulder pain at 5/10 and low back pain at 7/10. The patient is currently working with modified duty with restrictions of no lifting, carrying over 10 pounds, no sitting and standing long periods of time. The patient is currently taking Ibuprofen as needed. His right shoulder flexion is 95 degrees, extension is 30 degrees, abduction is 80 degrees and adduction is 30 degrees. There is tenderness over greater tuberosities, coracoid process and subacromial grinding and clicking. His lumbar flexion is 55 degrees and extension is 20 degrees. There is tightness and muscle spasm over paraspinal musculature. The lists of diagnoses are: 1) Right shoulder impingement syndrome rotator cuff tendinitis, positive MRI-tear. 2) Lumbar spine strain/ sprain, rule out radiculitis/ radiculopathy, secondary to herniated lumbar disc. 3) S/P left partial lateral claviclectomy due to automobile accident 3 years ago. 4) S/P right hand 3rd MCP, surgery due to automobile accident 3 years ago. Per 10/10/14 progress report, the patient has right shoulder pain. The patient is pending orthopedic surgery consultation. Per 08/12/14 physical therapy progress report, the patient rates his pain as 1-2/10. Per 12/05/14 physical therapy progress report, the patient rates his pain as 3/10. The utilization review determination being challenged is dated on 12/03/14. Treatment reports were provided from 06/06/14 to 11/18/14.

### 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 6 weeks for Lumbar Spine: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Page(s): 99. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back, Physical therapy

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

**Decision rationale:** The patient presents with pain in his right shoulder and lower back. The request is for 12 sessions of physical therapy for the lumbar spine. For non-post-operative therapy treatments, MTUS guidelines page(s) 98 and 99 allow 8-10 sessions for neuralgia, neuritis, and radiculitis, unspecified and 9-10 sessions for myalgia and myositis, unspecified. The review of the reports indicates that the patient has had 8 sessions of physical therapy between 08/12/14 and 12/05/14. Per 08/12/14 physical therapy progress report, the patient rates his pain as 1-2/10. Per 12/05/14 physical therapy progress report, the patient rates his pain as 3/10. Prior treatment appears to have failed and there is no explanation as to what can be accomplished with additional therapy. It would appear that the patient has had adequate therapy recently. The treater does not explain why the patient is unable to transition in to a home program. Furthermore, the current request for 8 combined with 8 already received would exceed what is recommended per MTUS guidelines. The request is not medically necessary.