

<b>Case Number:</b>	CM15-0179987		
<b>Date Assigned:</b>	09/21/2015	<b>Date of Injury:</b>	05/22/2011
<b>Decision Date:</b>	10/23/2015	<b>UR Denial Date:</b>	08/03/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	09/01/2015

### 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: Arizona, California

Certification(s)/Specialty: Family Practice

### 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 57 year old female who sustained an industrial injury on 5-22-11. The injured worker reported pain in the left upper extremity and back. A review of the medical records indicates that the injured worker is undergoing treatments for chronic pain, pain in joint shoulder, and cervical disc displacement without myelopathy. Medical records dated 7-24-15 indicate the injured worker "continues to have upper extremity left arm and hand neck and back pain." Provider documentation dated 7-24-15 noted the work status as permanent and stationary. Treatment has included lumbosacral spine magnetic resonance imaging (11-3-11), cervical spine magnetic resonance imaging (11-23-11), left shoulder magnetic resonance imaging (11-29-11), Ketamine cream, Voltaren Gel, and Tylenol. Objective findings dated 7-24-15 were notable for decreased sensation in the dermatomes left L3 and L5, left hip tenderness over greater trochanteric bursa noted. The original utilization review (8-3-15) denied a request for six physical therapy visits with evaluation.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Six Physical Therapy visits with Evaluation:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Neck and Upper Back Complaints 2004, and Shoulder Complaints 2004, and Low Back Complaints 2004. Decision based on Non-

MTUS Citation Official Disability Guidelines (ODG) Chapters: Neck and Upper Back, and Low Back-Lumbar & Thoracic (Acute & Chronic) Physical Therapy Guidelines.

**MAXIMUS guideline:** Decision based on MTUS Low Back Complaints 2004, Section(s): Initial Care, and Chronic Pain Medical Treatment 2009, Section(s): Physical Medicine.

**Decision rationale:** In this case, the claimant completed an unknown amount of therapy in the past. The guidelines recommend therapy in a weaning basis with additional exercises to be performed at home. The request for 6 additional therapy sessions was not justified. There was no indication that the exercises cannot be performed at home. The request for additional 6 sessions of physical therapy is not medically necessary.