

<b>Case Number:</b>	CM15-0026840		
<b>Date Assigned:</b>	02/19/2015	<b>Date of Injury:</b>	10/01/2004
<b>Decision Date:</b>	04/03/2015	<b>UR Denial Date:</b>	01/26/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	02/12/2015

### 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: Utah, Arkansas  
 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 60 year old female who sustained an industrial injury on 10/01/2004. Current diagnoses include unspecified disorder of joint of shoulder region, disorder of shoulder, abnormal involuntary movements, and tremor. Previous treatments included medication management and physical therapy. Report dated 01/19/2015 noted that the injured worker presented with complaints that included right shoulder pain and tremors, and right hand weakness. Physical examination was positive for abnormal findings. The utilization reviewer noted that the injured worker had completed 2 sessions of physical therapy for the right shoulder. Utilization review performed on 01/26/2015 non-certified a prescription for physical therapy for 12 visits for the right shoulder, based on the clinical information submitted does not support medical necessity. The reviewer referenced the California MTUS in making this decision.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Physical therapy times 12 visits for the Right Shoulder:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Pages 98-99.

**Decision rationale:** MTUS treatment guidelines were reviewed in regards to this specific case, and the clinical documents were reviewed. The request is for physical therapy sessions. MTUS guidelines state the following: Recommended as indicated below. Physical Medicine Guidelines Allow for fading of treatment frequency (from up to 3 visits per week to 1 or less), plus active self-directed home Physical Medicine. Myalgia and myositis, unspecified (ICD9 729.1): 9-10 visits over 8 weeks. Neuralgia, neuritis, and radiculitis, unspecified (ICD9 729.2) 8-10 visits over 4 weeks. Reflex sympathetic dystrophy (CRPS) (ICD9 337.2): 24 visits over 16 weeks. According to the clinical documentation provided and current MTUS guidelines; the current request of 12 sessions exceeds the recommended amount of therapy recommended, a modified request of 8 has been approved. The patient has completed 2 sessions. The request as is, Physical therapy x 12 sessions, is not indicated as a medical necessity to the patient at this time.