

<b>Case Number:</b>	CM15-0063586		
<b>Date Assigned:</b>	04/09/2015	<b>Date of Injury:</b>	11/13/2003
<b>Decision Date:</b>	05/08/2015	<b>UR Denial Date:</b>	03/04/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	04/03/2015

### 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: California

Certification(s)/Specialty: Emergency 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 44 year old male who sustained an industrial injury on 11/13/03. The injured worker reported symptoms in the neck and right shoulder. The injured worker was diagnosed as having right shoulder pain, status post right shoulder subacromial decompression, lumbar facet pain, right sacroilitis, clinically consistent cervical radiculopathy, bilateral knee pain and insomnia secondary to pain. Treatments to date have included psychotherapy treatment, injections, status post right shoulder subacromial decompression, oral pain medication, proton pump inhibitor, and activity modification. Currently, the injured worker complains of neck and right shoulder pain. The plan of care was for physical therapy and a follow up appointment at a later date.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Eight sessions of Physical Therapy:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Page(s): 98.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 181. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Neck and Upper Back, Acute and Chronic, Physical therapy.

**Decision rationale:** The requested eight sessions of Physical Therapy, is not medically necessary. American College of Occupational and Environmental Medicine (ACOEM), 2nd Edition, (2004), CHAPTER 8, Neck and Upper Back Complaints, Summary of Recommendations and Evidence, Page 181; and Official Disability Guidelines (ODG), Neck and Upper Back, Acute and Chronic, Physical therapy, recommend continued physical therapy with documented objective evidence of derived functional benefit. The injured worker has neck and shoulder pain. The treating physician has not documented sufficient objective evidence of derived functional benefit from completed physical therapy sessions, nor the medical necessity for additional physical therapy to accomplish a transition to a dynamic home exercise program. The criteria noted above not having been met, eight sessions of Physical Therapy is not medically necessary.