

<b>Case Number:</b>	CM14-0068078		
<b>Date Assigned:</b>	07/11/2014	<b>Date of Injury:</b>	07/17/2006
<b>Decision Date:</b>	10/13/2015	<b>UR Denial Date:</b>	04/25/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	05/12/2014

### 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: Massachusetts

Certification(s)/Specialty: Physical Medicine & Rehabilitation, Pain Management

### 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 54 year old female injured worker suffered an industrial injury on 7-17-2006. The diagnoses included right and left shoulder rotator cuff syndrome, cervical herniation and chronic thoracic strain. On 3-12-2015, the provider requested physical therapy. The neck pain was 6 out of 10, thoracic spine pain 4 out of 10, shoulder pain 4 out of 10 and wrist pain 6 out of 10. On 4-9-2015 the treating provider reported cervical spine, thoracic spine, bilateral shoulder and bilateral wrist pain. The neck pain was rated 7 out of 10 and radiated to both arms and mid back. The shoulder and wrist pain was rated 7 out of 10. She reported the Norco controlled the pain from 7 out of 10 down to 4 out of 10. The provider noted there were no signs of abuse. On exam the cervical spine slightly decreased range of motion. There was tenderness to the upper back. The shoulder depression test was positive. The thoracic spine was tender. The shoulders had decreased range of motion and joint tenderness. The wrists had decreased range of motion with weak grip strength. Prior treatments included rotator cuff repair to both shoulders and cervical fusion. Goals of treatment for physical therapy and evidence of any prior therapy were not included in the documentation provided. The Utilization Review on 4-25-2014 determined non-certification for Six (6) physical therapy visits, 2x a week for 3 weeks for the cervical spine.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Six (6) physical therapy visits, 2x a week for 3 weeks for the cervical spine:** Overturned

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ACOEM - [https://www.acoempracguides.org/Low Back, Table 2, Summary of Recommendations, Cervical and Thoracic Spine Disorders](https://www.acoempracguides.org/Low%20Back,%20Table%20,%20Summary%20of%20Recommendations,%20Cervical%20and%20Thoracic%20Spine%20Disorders).

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) (1) Chronic pain, Physical medicine treatment. (2) Preface, Physical Therapy Guidelines.

**Decision rationale:** The claimant sustained a work injury in July 2006 and is being treated for cervical, thoracic, and bilateral shoulder and wrist pain. When seen, there was persistent pain, which was frequent, and the same. Physical examination findings included a BMI of nearly 27. There was decreased cervical range of motion with cervical and trapezius muscle tenderness. There was decreased shoulder and wrist range of motion. Phalen and Tinel testing was positive bilaterally. There was decreased strength and sensation. Authorization for 6 physical therapy treatments was requested. In terms of physical therapy treatment for chronic pain, guidelines recommend a six visit clinical trial with a formal reassessment prior to continuing therapy. In this case, the claimant has not had physical therapy in the past 12 months and the number of requested visits is within guideline recommendations. The request was medically necessary. In terms of physical therapy treatment for chronic pain, guidelines recommend a six visit clinical trial with a formal reassessment prior to continuing therapy. In this case, there is no evidence of recent therapy or that the claimant is currently performing a home exercise program. There are impairments in strength that could improve with the requested treatments. The number of requested visits is within guideline recommendations. The request was medically necessary.