

|                       |              |                              |            |
|-----------------------|--------------|------------------------------|------------|
| <b>Case Number:</b>   | CM13-0023881 |                              |            |
| <b>Date Assigned:</b> | 11/15/2013   | <b>Date of Injury:</b>       | 07/30/2012 |
| <b>Decision Date:</b> | 01/16/2014   | <b>UR Denial Date:</b>       | 09/04/2013 |
| <b>Priority:</b>      | Standard     | <b>Application Received:</b> | 09/12/2013 |

### HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Physical Medicine and Rehabilitation and is licensed to practice in Oklahoma and Texas. 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 physician 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

### 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 36-year-old male who reported an injury on 07/30/2012. The patient is currently diagnosed with bicipital tendonitis, left shoulder impingement, and subdeltoid bursa inflammation. The patient was recently evaluated on 07/25/2013. The patient complained of cervical spine pain rating 6/10, left shoulder pain rating 7/10, and sharp, constant radiating pain to the left upper extremity with numbness and weakness. Physical examination revealed painful range of motion.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Physical therapy 2 times per week for 6 weeks for the left shoulder:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 203-204. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) - Shoulder Chapter.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 98-99. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Shoulder Chapter, Physical Therapy.

**Decision rationale:** California Chronic Pain Medical Treatment Guidelines state that active therapy is based on the philosophy that therapeutic exercise and/or activity is beneficial for

restoring flexibility, strength, endurance, function, range of motion, and can alleviate discomfort. Guidelines allow for fading of treatment frequency plus active self-directed home physical medicine. The Official Disability Guidelines state that treatment for impingement syndrome includes 10 visits over 8 weeks. As per the clinical notes submitted, the patient's latest physical examination only revealed limited range of motion. The current request for physical therapy twice per week for 6 weeks exceeds guideline recommendations. Based on the clinical information received, the requested physical therapy is not medically necessary and appropriate.