

<b>Case Number:</b>	CM13-0033833		
<b>Date Assigned:</b>	12/06/2013	<b>Date of Injury:</b>	04/04/2011
<b>Decision Date:</b>	02/28/2014	<b>UR Denial Date:</b>	10/03/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/11/2013

### 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 Family Practics and is licensed to practice in 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 61-year-old female who reported an injury on 04/04/2011. The mechanism of injury was not provided for review. The patient's injury to the left shoulder ultimately resulted in subacromial decompression. The patient's treatment history included postsurgical physical therapy and corticosteroid injections. There were no recent objective clinical findings to support the need for medical management. The patient's diagnoses included right shoulder and knee arthritis and impingement. The patient's treatment plan included physical therapy for the left knee.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Performed physical therapy, QTY 8:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Page(s): 98-99.

**Decision rationale:** The Physician Reviewer's decision rationale: The requested Performed physical therapy, QTY 8 is not medically necessary or appropriate. The clinical documentation submitted for review does provide evidence that the patient previously participated in physical

therapy. However, this physical therapy was directed towards the postsurgical management of the patient's shoulder injury. There is no documentation to support that the patient has ever received any physical therapy to the left knee. California Medical Treatment Utilization Schedule states "active therapy is based on the philosophy that therapeutic exercises and/or activity are beneficial for restoring flexibility, strength, endurance, function, range of motion, and can alleviate discomfort." The clinical documentation submitted for review does not provide any objective functional deficits that would benefit from active therapy. Additionally, Official Disability Guidelines recommend up to 9 physical therapy visits to include a 6 visit clinical trial to establish the efficacy of the treatment modality. The requested 8 treatments do fall within this guideline; however, there is no indication that the patient has undergone a trial of physical therapy to establish the efficacy of this treatment modality. Therefore, the requested 8 sessions would be in excess of guideline recommendations. There are no exceptional factors noted within the documentation to support extending treatment beyond guideline recommendations. As such, the requested Performed physical therapy, QTY 8 is not medically necessary or appropriate.