

<b>Case Number:</b>	CM13-0046917		
<b>Date Assigned:</b>	12/27/2013	<b>Date of Injury:</b>	04/26/2011
<b>Decision Date:</b>	04/18/2014	<b>UR Denial Date:</b>	10/22/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	11/04/2013

### 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. The expert reviewer is Board Certified in Physical Medicine & Rehabilitation, and is licensed to practice in California. 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/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:

According to the records made available for review, this is a 39-year-old female with a 4/26/11 date of injury. At the time (10/14/13) of request for authorization for Outpatient Physical therapy two (2) times a week for four (4) weeks for the right shoulder, there is documentation of subjective (right shoulder pain) and objective (tenderness in the shoulder over the anterior lateral aspect, restricted range of motion) findings, current diagnoses (impingement syndrome and pain in the shoulder), and treatment to date (physical therapy, activity modification, and medications). 4/8/13 medical report identifies plan for physical therapy 2 times a week for 4 weeks. There is no documentation of functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications or medical services as a result of the previous physical therapy provided.

### IMR ISSUES, DECISIONS AND RATIONALES

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

#### **OUTPATIENT PHYSICAL THERAPY TWO (2) TIMES A WEEK FOR FOUR (4) WEEKS FOR THE RIGHT SHOULDER: Upheld**

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

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

(ODG) Shoulder, Physical therapy (PT); and Title 8, California Code of Regulations, section 9792.20

**Decision rationale:** MTUS Chronic Pain Medical Treatment Guidelines support a brief course of physical medicine for patients with chronic pain not to exceed 10 visits over 4-8 weeks with allowance for fading of treatment frequency, with transition to an active self-directed program of independent home physical medicine/therapeutic exercise. MTUS-Definitions identifies that any treatment intervention should not be continued in the absence of functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications or medical services. ODG recommends a limited course of physical therapy for patients with a diagnosis of shoulder impingement syndrome not to exceed 10 sessions over 8 weeks; and documentation of exceptional factors when treatment duration and/or number of visits exceed the guidelines. Within the medical information available for review, there is documentation of diagnoses of impingement syndrome and pain in the shoulder. In addition, there is documentation of previous physical therapy treatments (8 physical therapy treatments prescribed 4/8/13). Furthermore given documentation of subjective (right shoulder pain) and objective (tenderness in the shoulder over the anterior lateral aspect, restricted range of motion) findings, there is documentation of functional deficits and functional goals. However, there is no documentation of functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications or medical services as a result of the previous physical therapy provided. In addition, the current request, along with the physical therapy treatments provided to date, will exceed guidelines, and there is no documentation of exceptional factors to justify exceeding guidelines. Therefore, based on guidelines and a review of the evidence, the request for Outpatient Physical therapy two (2) times a week for four (4) weeks for the right shoulder is not medically necessary.