

<b>Case Number:</b>	CM13-0048522		
<b>Date Assigned:</b>	12/27/2013	<b>Date of Injury:</b>	06/17/2011
<b>Decision Date:</b>	03/12/2014	<b>UR Denial Date:</b>	10/02/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	11/06/2013

### 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 New York 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 65-year-old who reported an injury on 06/17/2011. The patient is diagnosed with rotator cuff tendinitis, as well as ac joint arthrosis, cervical degenerative disc disease with radiculopathy, lumbar herniated nucleus pulposus, and myelopathy. The most recent Physician's Progress Report was submitted on 12/17/2013 by [REDACTED]. The patient reported improvement in shoulder pain. Physical examination revealed full range of motion of the cervical spine, full range of motion of the bilateral shoulders, mild tenderness over the AC joint, and 5/5 strength in the rotator cuff. Treatment recommendations included initiation of physical therapy.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Physical therapy for the lumbar and right shoulder, twice per week for six weeks:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines.

**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 Section.

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

flexibility, strength, endurance, function, range of motion, and can alleviate discomfort. The guidelines allow for a fading of treatment frequency, plus active, self-directed home physical medicine. As per the documentation submitted, the patient has previously participated in a course of physical therapy. Documentation of a significant musculoskeletal or neurological deficit was not provided. The patient's physical examination was on 12/17/2013 revealed full range of motion of the cervical spine and bilateral shoulders. Additionally, the request for physical therapy twice per week for 6 weeks exceeds guideline recommendations. The request for physical therapy for the lumbar and right shoulder, twice per week for six weeks, is not medically necessary or appropriate.