

<b>Case Number:</b>	CM13-0055212		
<b>Date Assigned:</b>	12/30/2013	<b>Date of Injury:</b>	02/13/2012
<b>Decision Date:</b>	04/30/2014	<b>UR Denial Date:</b>	10/23/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	11/18/2013

### 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 Orthopedic Surgery and Hand Surgery 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 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:

The injured worker is a 43-year-old female who reported an injury on 02/13/2012. The mechanism of injury was not provided in the medical records. The injured worker was diagnosed with acromioclavicular sprain. The injured worker's complaints included constant daily pain and discomfort rated at 5/10. She described popping, weakness, limited range of motion, and clicking mainly when lifting. There was no numbness or tingling. Any overhead activities aggravated the pain. Examination of the right shoulder revealed active range of motion of flexion 160, abduction 155, external rotation 50, and internal rotation L1-2. The injured worker had a positive crepitus. X-ray examination of the right shoulder demonstrated AC arthrosis with a slightly elevated AC joint, consistent with grade I to grade II AC separation. Past medical treatment included cortisone injection, right shoulder surgery in 11/2012, and physical therapy. On 10/15/2013, a request for physical therapy for the left shoulder 3 times a week for 6 weeks was made due to the injured worker's residual shoulder pain and the weakness, with emphasis on core strengthening and trunk stabilization, as well as soft tissue edema control and modalities.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**PHYSICAL THERAPY FOR THE LEFT SHOULDER, THREE TIMES PER WEEK FOR SIX WEEKS:** 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): 98-99.

**Decision rationale:** According to the California Guidelines, physical therapy allows for fading of treatment frequency from up to 3 visits per week to 1 or less, plus active self-directed home physical medicine in the condition of myalgia and myositis at 9 visits to 10 visits. The most recent clinical note indicated the injured worker continued to have constant daily pain and discomfort. The injured worker was noted to have popping, weakness, limited range of motion, and clicking mainly when lifting the right shoulder. The documentation submitted for review indicated the injured worker has completed an unknown number of physical therapy sessions between 12/13/2012 and 05/15/2013 with documented functional gains. However, the documentation submitted for review failed to provide evidence of exceptional factors needed to warrant further physical therapy. Due to a lack of documented exceptional factors, additional therapy is not supported. Additionally, the documentation submitted for review provided details regarding the right shoulder; as the request is for the left shoulder, the request is not supported. Given the above, the request for Physical Therapy for the Left Shoulder, 3 times per week for 6 weeks is not medically necessary.