

<b>Case Number:</b>	CM13-0062709		
<b>Date Assigned:</b>	12/30/2013	<b>Date of Injury:</b>	03/07/2012
<b>Decision Date:</b>	04/15/2014	<b>UR Denial Date:</b>	12/02/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	12/09/2013

### 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 Physical Medicine & Rehabilitation, and is licensed to practice in Illinois. 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 patient is a 52-year-old female who reported an injury on 03/07/2012. The mechanism of injury was not specifically stated. The patient is currently diagnosed with medial and patellofemoral damage with aggravation to the right knee, bilateral partial rotator cuff tear with scapular dysfunction, and status post right knee arthroscopy with synovectomy and chondroplasty. The patient was seen by [REDACTED] on 10/07/2013. Physical examination revealed 0 degrees to 130 degrees range of motion of the right knee with mild crepitus and 4/5 motor strength. Physical examination of the bilateral shoulders was not provided on that date. Treatment recommendations included work limitations and authorization for right shoulder physical therapy.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**SCAP BASED REHABILITATION FOR BILATERAL SHOULDERS (3 TIMES PER WEEK FOR 4 WEEKS): Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 98. Decision based on Non-MTUS Citation OFFICIAL DISABILITY GUIDELINES (ODG), PHYSICAL THERAPY GUIDELINES.

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

**Decision rationale:** California MTUS 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. Guidelines allow for fading of treatment frequency, plus active, self-directed home physical medicine. As per the documentation submitted, the patient has completed a substantial amount of physical therapy to date. However, documentation of objective measurable improvement following an initial course of physical therapy was not provided. There is no physical examination provided on the requesting date of 10/07/2013. Additionally, the current request for physical therapy 3 times per week for 4 weeks exceeds guideline recommendations. Based on the clinical information received and California MTUS Guidelines, the request is non-certified.