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| <b>Case Number:</b>   | CM13-0068060 |                              |            |
| <b>Date Assigned:</b> | 01/03/2014   | <b>Date of Injury:</b>       | 03/11/2010 |
| <b>Decision Date:</b> | 05/21/2014   | <b>UR Denial Date:</b>       | 11/26/2013 |
| <b>Priority:</b>      | Standard     | <b>Application Received:</b> | 12/19/2013 |

### 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 and Rehabilitation, has a subspecialty in Pain Management 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:

This is a female patient with the date of injury of July 8, 2011. A utilization review determination dated November 20, 2013 recommends modification of physical therapy 2 times a week for 6 weeks bilateral shoulders. The previous reviewing physician recommended modification of physical therapy 2 times a week for 6 weeks bilateral shoulders due to being consistent with guideline recommendations and to allow for instruction and oversight of an independent home program of exercise and strengthening. A Progress Report dated November 11, 2013 identifies she underwent surgery on the right shoulder on July 11, 2013 for rotator cuff repair, excision of distal clavicle, and subacromial decompression. She states that she has had improvement of pain in her right shoulder following surgery and continues to work on therapeutic exercises to regain her motion. She still notes some limited motion of the shoulder. She currently complains of increased pain about the left shoulder. Physical Examination identifies active forward elevation to 125 degrees and abduction to 65 degrees. External rotation and internal rotation are still limited. Assessment identifies left shoulder rotator cuff tendinitis, left shoulder subacromial bursitis, possible SLAP lesion left shoulder, right rotator cuff tear, arthroscopy and rotator cuff repair, and right AC joint arthritis - status post excision of distal clavicle. Discussion identifies recommend that physical therapy for her right shoulder continue twice a week for the next six weeks to regain full range of motion and strength and a course of therapy for the left shoulder twice a week for the next six weeks to address significant left shoulder tendinitis.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**PHYSICAL THERAPY FOR LUMBAR SPINE: TWO (2) TIMES A WEEK FOR SIX (6) WEEKS:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS ACOEM,Chronic Pain Treatment Guidelines Low Back Chapter Page(s): 98 & 298.

**Decision rationale:** Chronic Pain Medical Treatment Guidelines recommend a short course of active therapy with continuation of active therapies at home as an extension of the treatment process in order to maintain improvement levels. ODG recommends a trial of physical therapy. If the trial of physical therapy results in objective functional improvement, as well as ongoing objective treatment goals, then additional therapy may be considered. Within the documentation available for review, the request is for physical therapy for the lumbar spine. However, the documented findings address the shoulder. Symptoms and findings regarding the lumbar spine are not identified. Therefore, there are no objective treatment goals with regards to the patient's lumbar spine. In the absence of clarity regarding these issues, the current request for physical therapy for lumbar spine: two (2) times a week for six (6) weeks is not medically necessary.