

<b>Case Number:</b>	CM13-0071723		
<b>Date Assigned:</b>	01/08/2014	<b>Date of Injury:</b>	02/24/2012
<b>Decision Date:</b>	07/07/2014	<b>UR Denial Date:</b>	12/09/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	12/30/2013

### 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, has a subspecialty in Sports Medicine, and is licensed to practice in Texas & Oklahoma. 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 52-year-old male who reported an injury on 02/24/2012. The mechanism of injury was not stated. Current diagnoses include right shoulder adhesive capsulitis, lumbosacral strain, internal medicine diagnoses, erectile dysfunction, sleep disturbance, migraine headaches, and psychiatric diagnoses. The injured worker was evaluated on 10/02/2013. The injured worker was actively participating in a home exercise program for the right shoulder and lumbar spine. Previous conservative treatment for the right shoulder also includes injections into the subacromial space or acromioclavicular joint, physical therapy, and acupuncture. Physical examination revealed low back tenderness, positive straight leg raising, limited lumbar range of motion, and limited shoulder range of motion. It is noted, the injured worker has undergone an MRI of the right shoulder, which indicated partial tearing of the mid and posterior rotator cuff. Treatment recommendations at that time included authorization for 12 visits of physical therapy for the right shoulder.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**PHYSICAL THERAPY 2XWEEK X6WEEKS RIGHT SHOULDER:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints.

**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.

**Decision rationale:** The 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 a fading of treatment frequency plus active self-directed home physical medicine. It is noted, the injured worker has undergone an MRI of the right shoulder, which indicated partial tearing of the mid and posterior rotator cuff. The Official Disability Guidelines state physical medicine treatment for rotator cuff syndrome includes 10 visits over 8 weeks. The current request for 12 sessions of physical therapy exceeds guideline recommendations. There is also no evidence of a significant improvement following the initial course of physical therapy that would warrant the need for additional treatment. Based on the clinical information received, the request is non-certified.