

<b>Case Number:</b>	CM13-0071932		
<b>Date Assigned:</b>	05/14/2014	<b>Date of Injury:</b>	07/28/2011
<b>Decision Date:</b>	07/10/2014	<b>UR Denial Date:</b>	11/21/2013
<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 Anesthesiology, has a subspecialty in Pain Medicine and is licensed to practice in Florida. 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 53 year old female who reported an injury on 07/28/2011. The mechanism of injury was reported to be from a fall. Per the comprehensive report dated 09/23/2013 the injured worker sustained another fall in July 2011 injuring her right shoulder, the injured worker underwent surgery to her right shoulder in 2011. She also underwent right knee arthroscopy in November 2011. Per the comprehensive report dated 11/04/2013 the injured worker was reported to have crepitus over the right shoulder and decreased range of motion. Flexion was 120 degrees, extension was 10 degrees and abduction was 110 degrees to the right shoulder. The diagnoses for the injured worker included patellofemoral chondromalacia of the right knee, bilateral ulnar triquetral impaction syndrome, TFCC tear of the right wrist, possible TFCC tear of the left wrist and early medial compartment arthropathy of the right knee. The request for authorization for medical treatment was not provided in the documentation.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**PHYSICAL THERAPY (PT), 3 X PER WEEK FOR 4 WEEKS, FOR THE RIGHT SHOULDER:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines  
PHYSICAL MEDICINE.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Page(s): 98-99. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Shoulder, Physical Therapy.

**Decision rationale:** Per CA MTUS guidelines physical medicine is recommended with the following guidelines. Myalgia and myositis, unspecified, 9-10 visits over 8 weeks and neuralgia, neuritis, and radiculitis, unspecified, 10 visits over 4 weeks. The guidelines also recommend fading of treatment frequency (from up to 3 visits per week to 1 or less), plus active self-directed home Physical Medicine. The Official Disability Guidelines state that for rotator cuff syndrome/Impingement syndrome the guidelines recommend medical treatment of 10 visits over 8 weeks. The documentation provided indicated the injured worker underwent physical therapy after her right shoulder surgery in 2011 and had been participating in a home exercise program since that time. The efficacy of the physical therapy was unclear within the medical records. In addition there is a lack of documentation regarding the need for any additional physical therapy sessions. The guidelines recommend no more than 10 visits over 4 weeks and also to allow for fading of treatment. Therefore the request for physical therapy 3 times a week for 4 weeks for the right shoulder is non-certified.