

<b>Case Number:</b>	CM14-0012392		
<b>Date Assigned:</b>	02/21/2014	<b>Date of Injury:</b>	03/30/2009
<b>Decision Date:</b>	06/26/2014	<b>UR Denial Date:</b>	01/17/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	01/30/2014

### 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 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 66-year-old female who sustained an injury to her right shoulder on three 3009 through cumulative trauma while performing her customary duties as a merchandiser. She was required to reset all the merchandise that required her to removal products, clean, re-shelf and replace new products when she began to have pain in the neck and right upper extremity. She has self treated with over-the-counter medications, rubs, patches, but the pain returned and is now at 4/10 VAS. The records indicate that the injured worker is status post right shoulder arthroscopy with intra-articular debridement of superior labrum and arthroscopic revision subacromial decompression dated 10/06/10.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**PHYSICAL THERAPY THREE TIMES A WEEK FOR FOUR WEEKS FOR THE RIGHT SHOULDER:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation MTUS: CHRONIC PAIN MEDICAL TREATMENT GUIDELINES, ROTATOR CUFF SYNDROME/IMPINGEMENT SYNDROME, 27

**Decision rationale:** The request for physical therapy three times a week times four weeks for the right shoulder is not medically necessary. The previous request was denied on the basis that there was no recent detailed physical examination and no physical therapy/occupational therapy notes provided for review that would indicate the amount of physical therapy visits that the injured worker has completed to date or the injured worker's response to any previous conservative treatment. Given that there were conflicting surgery dates, no physical examination or physiotherapy notes and the limited clinical documentation submitted for review, medical necessity of the request for physical therapy three times a week times four weeks had not been established. The Chronic Pain Medical Treatment Guidelines recommends up to 24 visits over 14 weeks for the diagnosed injury. There is no additional significant objective clinical information provided that would support the need to exceed the Chronic Pain Medical Treatment Guidelines recommendations, either in frequency or duration of physical therapy visits. Given the clinical information submitted for review, medical necessity of the request for physical therapy three times a week times four weeks for the right shoulder has not been established. Therefore the request is not medically necessary.