

<b>Case Number:</b>	CM14-0129564		
<b>Date Assigned:</b>	08/20/2014	<b>Date of Injury:</b>	07/01/2011
<b>Decision Date:</b>	09/23/2014	<b>UR Denial Date:</b>	08/07/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	08/14/2014

### 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 Physical Medicine and Rehabilitation 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:

The injured worker is a 28 year old male who reported an injury on 07/01/2011. The mechanism of injury was not provided for clinical review. The diagnoses includes sprain of unspecified site of the shoulder and upper arm, neck sprain. The previous treatments include medications, 12 sessions of physical therapy, subacromial injections. Diagnostic testing included an MRI, EMG/NCV. Within the clinical note dated 07/30/2014, it was reported the injured worker complained of right shoulder, neck and upper back pain. The injured worker reported the pain radiated to the right arm. He described the pain as throbbing pain. The injured worker reported having nocturnal pain, numbness, swelling, tingling in the arms and weakness. Upon the physical examination the provider noted tenderness to palpation of the supraspinatus and infraspinatus. The active range of motion on extension was 45 degrees and flexion at 170 degrees. The provider requested physical therapy to prevent further frozen shoulder. The Request for Authorization was submitted and dated on 07/30/2014.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**PHYSICAL THERAPY 2XWK X 3WKS CERVICAL AND RIGHT SHOULDER:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints.

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

**Decision rationale:** The MTUS Chronic Pain Guidelines state that active therapy is based on the philosophy that therapeutic exercise and/or activity are beneficial for restoring flexibility, strength, endurance, function and range of motion. The guidelines allow for fading of treatment frequency plus active self directed home physical medicine. The guidelines note for neuralgia and myalgia 8 to 10 visits of physical therapy are recommended. There is lack of documentation indicating the injured worker's prior course of physical therapy, as well as the efficacy of the prior therapy. The injured worker has utilized 12 sessions of physical therapy, the request submitted exceeds the guidelines recommendation of 8 to 10 visits. Therefore, the request is not medically necessary.