

<b>Case Number:</b>	CM14-0147317		
<b>Date Assigned:</b>	09/15/2014	<b>Date of Injury:</b>	08/16/2012
<b>Decision Date:</b>	11/03/2014	<b>UR Denial Date:</b>	08/18/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	09/10/2014

### 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 Occupational Medicine 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 patient is a 43 year-old male with date of injury 08/16/2012. The medical document associated with the request for authorization, a primary treating physician's progress report, dated 08/07/2014, list subjective complaints as pain in the left shoulder and neck. Objective findings: Examination of the left shoulder revealed positive Neer's sign and Hawkin's impingement signs. Negative cross arm testing. Negative O'Brien's testing. Forward flexion and abduction was to 170 degrees and internal rotation was to L4. Strength was 4/5. Diagnosis: left rotator cuff tendinitis 2. Peroneus longus tendon sheath inflammation of the ankle. Patient has completed 12 sessions of physical therapy for the left shoulder to date.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Additional physical therapy 2x6 (left shoulder) QTY: 12: Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 58-60.

**Decision rationale:** The MTUS Chronic Pain Medical Treatment Guidelines state that 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. Continued physical therapy is predicated upon demonstration of a functional improvement. There is no documentation of objective functional improvement.