

<b>Case Number:</b>	CM14-0155338		
<b>Date Assigned:</b>	09/25/2014	<b>Date of Injury:</b>	09/11/2009
<b>Decision Date:</b>	10/27/2014	<b>UR Denial Date:</b>	09/12/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	09/23/2014

### 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 Orthopaedic Surgery, 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 57-year-old male driver sustained an industrial injury on 9/11/09 relative to lifting. The patient was diagnosed with a high-grade near complete partial thickness tear of the distal biceps with proximal retraction of some of the torn tendon fibers. He underwent right biceps repair in March 2010. A right wrist flexor tenosynovectomy, open carpal tunnel release and Guyon's canal release was performed on 2/3/12. The patient was diagnosed with right shoulder acromioclavicular (AC) joint arthrosis, biceps tendinitis, and chronic calcific tendinitis, and left shoulder severe AC joint arthrosis and biceps tendinitis. Records indicated that 12 visits of physical therapy were prescribed for the shoulders on 6/9/14. The 7/25/14 treating physician report indicated that the patient had attended physical therapy sessions without any improvement. He was not happy with his treatment and wanted to switch therapists. Shoulder pain was constant and localized to the lateral deltoid region bilaterally. Physical exam documented forward flexion to 110 degrees with fairly significant pain. Muscle testing demonstrated 4+/5 external rotation strength, and 4/5 internal rotation and abduction strength on the right. On the left, there was 5/5 external rotation and 4+/5 internal rotation and abduction strength. The treatment plan recommended one-on-one physical therapy at a different venue twice a week for 6 weeks and bilateral corticosteroid injections of the AC joints. The 9/12/14 utilization review denied the request for bilateral shoulder physical therapy as the patient had completed at least 18 therapy sessions to date with no objective indications of progressive or clinical significant improvement from prior therapy to support the medical necessity of additional therapy over a home exercise program.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Physical therapy left shoulder:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Physical medicine Page(s): 9, 98-99. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Shoulder, Physical therapy

**Decision rationale:** The California MTUS guidelines recommend therapies focused on the goal of functional restoration rather than merely the elimination of pain. The physical therapy guidelines state that patients are expected to continue active therapies at home as an extension of treatment and to maintain improvement. In general, the MTUS guidelines would support 9 to 10 visits for myalgia/myositis. The Official Disability Guidelines provide specific physical therapy treatment guidelines for shoulder injuries that would support 9 visits for this patient's diagnosis. Guideline criteria have not been met for additional physical therapy to the left shoulder. The patient has completed at least 12 recent physical therapy visits with no evidence of objective functional improvement. There is limited bilateral shoulder range of motion with fairly significant pain and slight left shoulder weakness. A corticosteroid injection has been recommended. There is no compelling reason to support the medical necessity of an additional prescription of physical therapy with no frequency/duration specified. The medical necessity of additional supervised physical therapy over a home exercise program is not established. Therefore, this request is not medically necessary.

**Physical therapy right shoulder:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Physical medicine Page(s): 9, 98-99. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Shoulder, Physical therapy

**Decision rationale:** The California MTUS guidelines recommend therapies focused on the goal of functional restoration rather than merely the elimination of pain. The physical therapy guidelines state that patients are expected to continue active therapies at home as an extension of treatment and to maintain improvement. In general, the MTUS guidelines would support 9 to 10 visits for myalgia/myositis. The Official Disability Guidelines provide specific physical therapy treatment guidelines for shoulder injuries that would support 9 visits for this patient's diagnosis. Guideline criteria have not been met for additional physical therapy to the right shoulder. The patient has completed at least 12 recent physical therapy visits with no evidence of objective functional improvement. There is limited bilateral shoulder range of motion with fairly significant pain and mild right shoulder weakness. A corticosteroid injection has been recommended. There is no compelling reason to support the medical necessity of an additional

prescription of physical therapy with no frequency/duration specified. The medical necessity of additional supervised physical therapy over a home exercise program is not established. Therefore, this request is not medically necessary.