

<b>Case Number:</b>	CM14-0158614		
<b>Date Assigned:</b>	10/02/2014	<b>Date of Injury:</b>	04/12/2013
<b>Decision Date:</b>	10/29/2014	<b>UR Denial Date:</b>	08/26/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	09/26/2014

### 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, has a subspecialty in Pain Management, 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 is a patient of the date of injury of April 12, 2013. A utilization review determination dated August 26, 2014 recommends noncertification for physical therapy 8 visit for the right upper extremity. A progress report dated February 21, 2014 identifies subjective complaints of continued burning pain in the right arm. Objective examination identifies tenderness to palpation over the right trapezius and right posterior shoulder girdle with reduced range of motion in the right shoulder. Sensory and motor examination is normal. No diagnosis or treatment plan is included.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Physical therapy for the right upper extremity, twice weekly for four weeks:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 200. Decision based on Non-MTUS Citation Shoulder Chapter, Physical Therapy

**Decision rationale:** Regarding the request for physical therapy, Chronic Pain Medical Treatment Guidelines recommend a short course of active therapy with continuation of active therapies at

home as an extension of the treatment process in order to maintain improvement levels. ODG has more specific criteria for the ongoing use of physical therapy. ODG recommends a trial of physical therapy. If the trial of physical therapy results in objective functional improvement, as well as ongoing objective treatment goals, then additional therapy may be considered. ODG Recommends 10 physical therapy visits for a sprained rotator cuff. Within the documentation available for review, there is no indication of any specific objective treatment goals and no statement indicating why an independent program of home exercise would be insufficient to address any objective deficits. Furthermore, the request exceeds the amount of PT recommended by the CA MTUS as a trial for this patient's (inferred) diagnosis and, unfortunately, there is no provision for modification of the current request. In the absence of such documentation, the request for physical therapy for the right upper extremity, twice weekly for four weeks, is not medically necessary or appropriate.