

<b>Case Number:</b>	CM14-0026192		
<b>Date Assigned:</b>	06/16/2014	<b>Date of Injury:</b>	07/01/2013
<b>Decision Date:</b>	07/31/2014	<b>UR Denial Date:</b>	01/30/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	02/28/2014

### 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 & Rehabilitation and is licensed to practice in Illinois. 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 33-year-old male who reported an injury on 07/01/2013. The mechanism of injury was not provided. The clinical note dated 04/18/2014 noted the injured worker presented with lower back and bilateral shoulder pain. The injured worker reported muscle aches, muscle weakness in the bilateral shoulders, joint pain in the bilateral shoulders, back pain and swelling in the extremities. Upon examination, the injured worker had good range of motion in the shoulders, and noted discomfort when raising the arms above 90 degrees at the shoulder joints, particularly on the right side. The diagnoses were rotator cuff shoulder syndrome and allied disorders, shoulder joint pain, fibromyositis, and low back pain. There was no prior treatment listed. The provider recommended physical therapy 2 times a week for 4 weeks for the back and shoulders. The provider's rationale was not provided. The Request for Authorization form was not included in the medical documents for review.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**PHYSICAL THERAPY TWO TIMES A WEEK FOR FOUR WEEKS FOR BACK AND SHOULDERS.:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines : CHRONIC PAIN MEDICAL TREATMENT GUIDELINES Page(s): 98-9.

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

**Decision rationale:** The California MTUS states 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. Active therapy requires an internal effort by the individual to complete a specific exercise or task. Individual workers are instructed and expected to continue active therapies at home as an extension of the treatment process in order to maintain improvement levels. There was a lack of documentation indicating the injured worker's prior course of physical therapy, as well as the efficacy of the prior therapy. The guidelines allow for up to 10 visits of physical therapy. The amount of physical therapy visits that have already been completed was not provided. An adequate examination of the injured worker was not provided detailing current deficits in relation to the back and shoulders to warrant physical therapy. Therefore, the request for physical therapy two times a week for four weeks for back and shoulders is not medically necessary and appropriate.