

<b>Case Number:</b>	CM14-0033114		
<b>Date Assigned:</b>	06/20/2014	<b>Date of Injury:</b>	05/18/2013
<b>Decision Date:</b>	09/25/2014	<b>UR Denial Date:</b>	03/03/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	03/14/2014

### 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 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 53 year-old male who reported a work related injury on 05/18/2013 which reportedly occurred to his shoulder during an altercation. The diagnoses consist of a left shoulder strain with possible internal derangement. The past treatments have consisted of physical therapy, medication, and surgery. His surgical history consisted of a left shoulder arthroscopy with labral repair, subacromial decompression, and extensive debridement. An MRI revealed a labral tear. On 01/29/2014 there was a physical therapy evaluation that revealed the injured workers complaints consisted of intermittent shoulder pain with movement. The physical therapy note date 02/12/2014 indicated that the injured worker's symptoms included shoulder pain with movement. The injured worker was noted to have a good tolerance to manual treatment with improved range of motion and a positive response to manual stabilization of humeral head with passive movement with decreased discomfort, and increased fatigue with new exercises but no pain. Continued treatment was recommended. The request for authorization form was not submitted for review.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Physical therapy 3 times a week for 8 weeks for the left shoulder:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM, Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines.

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

**Decision rationale:** The request for Physical therapy 3 x 8 for the left shoulder is not medically necessary. The California MTUS Guidelines state up to 10 visits of physical therapy may be supported to promote functional gains in patients with unspecified myalgia and myositis. However, in order to determine whether additional physical therapy treatment is necessary, evidence of measurable objective functional gains are needed. Within the documentation provided, it was noted that the injured worker had good tolerance to manual therapy and improved range of motion. It was also noted that the injured worker was able to do more with less pain. However, there was insufficient evidence submitted showing objective functional gains made with therapy thus far. There was also no evidence of remaining functional deficits on physical examination and the requested number of visits exceeds the total number of visits recommended by the guidelines for the patient's condition. For these reasons, the request for Physical therapy 3 x 8 for the left shoulder is not medically necessary.