

<b>Case Number:</b>	CM14-0040379		
<b>Date Assigned:</b>	06/04/2014	<b>Date of Injury:</b>	03/22/2013
<b>Decision Date:</b>	07/11/2014	<b>UR Denial Date:</b>	03/25/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	04/07/2014

### 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 Medicine, and is licensed to practice in Minnesota. 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 54 year old female who reported on injury on 03/22/2013. The mechanism of injury was swinging a bottle when the injured worker felt a twisting injury in her left shoulder. The injured worker complained of left shoulder pain and weakness that is exacerbated by overhead activities. Upon physical examination range of motion is limited with 160 degrees of flexion and abduction, internal rotation of 10 degrees and external rotation of 20 degrees. The grip strength was 30/30/20 on the right and 10/10/0 on the left. Additionally motor strength is 4+/5 for the supraspinatus. The two point discrimination is 6mm in all digits and positive impingement test I and II. X-rays of the left shoulder and humerus show spurring on the undersurface of the acromion. The injured worker has a diagnosis of impingement syndrome of the left shoulder with a possible rotator cuff tear. The injured worker has completed 8 visits of physical therapy as of 03/10/2014. The injured workers medications include Hydrocodone, Diclofenac, Pantoprazole and Cyclobenzaprine. The request for authorization form for physical therapy for the lower back was not submitted with the documentation.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**PHYSICAL THERAPY THREE (3) TIMES A WEEK FOR FOUR (4) WEEKS FOR THE LOWER BACK:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Chronic Pain Medical Treatment Guidelines, Physical Medicine Guidelines, Page 99, online edition.

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

**Decision rationale:** The request for physical therapy 3 times a week for 4 weeks for the lower back is non-certified. Documentation provided dated 02/19/2014 noted the date of injury as 03/22/2013 to the left shoulder. There is documentation dated 03/19/2014 that has recorded a total of 8 completed visits of physical therapy for the low back. However, additional documentation dated 04/18/2014 has recorded a total of 8 completed visits of physical therapy with the last date of service on 03/10/2014. That documentation has the body part listed as the shoulder/upper arm and date of injury 12/16/2008. The California MTUS for physical therapy allows for fading of treatment frequency (from up to 3 visits per week to 1 or less), plus active self-directed home physical medicine. The guidelines recommend a total of 10 visits for the injured worker's condition. There is a lack of documentation submitted for review to support lumbar functional deficits. The documentation submitted for review is unclear if the injured worker has completed 8 visits of physical therapy for the low back or upper arm or completed 16 visits for both. In addition the documentation does not indicate that it will "allow for fading of treatment frequency". Based on the above mentioned, the request is not medically necessary and appropriate.