

<b>Case Number:</b>	CM14-0045081		
<b>Date Assigned:</b>	07/02/2014	<b>Date of Injury:</b>	03/08/2012
<b>Decision Date:</b>	08/22/2014	<b>UR Denial Date:</b>	03/21/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	04/14/2014

### 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 Anesthesiology, has a subspecialty in Pain Management and is licensed to practice in Florida. 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 43-year-old female who reported an injury on 03/08/2012. The mechanism of injury was not provided with this review. Her diagnoses was noted to be sprain/strain of the shoulder and olecranon bursitis. The injured worker had a prior treatment of physical therapy and medications. A primary treating physician's progress report dated 12/12/2013 notes the injured worker still waiting for surgical approval. She complained of problems with her hand and shoulder. The objective findings included the injured worker being alert and conversant with no negative effect of medications noted in the examination. The injured worker continued to have complaints of tenderness with the left wrist and shoulder. The treatment plan was to continue medications. Her medications were noted to be gabapentin, Tylenol No.3 and baclofen. The provider's rationale for the request was not provided within the documentation and a request for authorization for medical treatment was not provided within the documentation 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 for the left shoulder, 3 times a week for 4 weeks, QTY: 12: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Online Version, Chapter- Shoulder.

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

**Decision rationale:** The request for physical therapy for the left shoulder, 3 times a week for 4 weeks, quantity 12 not medically necessary. The California MTUS/Chronic Pain Medical Treatment Guidelines recommend active therapy based on the philosophy that therapeutic exercise and/or activities 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. Patients are instructed and expected to continue active therapies at home as an extension of the treatment process in order to maintain improvement levels. Home exercises can include exercise with or without mechanical assistance or resistance in functional activities with assistive devices. The guidelines allow for fading of treatment frequency (from up to 3 visits per week to 1 or less), plus active self-directive home physical medicine. The guidelines allow up to 10 visits over 8 weeks. The request is in excess of the number of visits recommended by the guidelines. In addition, the primary treating physician's progress report fails to provide an adequate assessment of the injured worker's objective functional deficits, range of motion, values and motor strength scores. Therefore, the request for physical therapy for the left shoulder, 3 times a week for 4 weeks, quantity 12 is not medically necessary.