

<b>Case Number:</b>	CM14-0065921		
<b>Date Assigned:</b>	07/11/2014	<b>Date of Injury:</b>	07/01/2011
<b>Decision Date:</b>	09/10/2014	<b>UR Denial Date:</b>	05/02/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	05/09/2014

### 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 with a date of injury of 7/1/11. A utilization review determination dated 5/2/14 recommends modification of PT from 10 sessions to 6 sessions. A teleconference with the provider noted that the patient has evidence of a severely frozen shoulder that was not treated in the prior course of therapy and has worsened. The utilization reviewer noted that "10 sessions was in excess of guideline recommendations, and a treatment modification for 6 sessions was offered and accepted." A 4/18/14 medical report was referenced, identifying constant mild pain. On exam, right shoulder flexion was 170 degrees and extension was 45 degrees. 3/17/14 medical report identifies right shoulder forward flexion to 160, extension 50, abduction 160, adduction 50, ER 80, and IR 80. The orthopedic surgeon recommended no additional diagnostic workup or treatment for the shoulder.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Physical Therapy 2 times a week for 5 weeks (10) Right Shoulder:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines 9792.20 - 9792.26 MTUS (Effective July 18, 2009), Physical Medicine Page(s): 98-99 of 127. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Preface.

**Decision rationale:** Regarding the request for physical therapy, California MTUS supports up to 10 PT sessions and cites that "patients are instructed and expected to continue active therapies at home as an extension of the treatment process in order to maintain improvement levels." ODG recommends initial treatment with 6 sessions prior to additional therapy in order to evaluate efficacy. Within the documentation available for review, it appears that the provider recommended additional PT since prior PT did not address frozen shoulder described as severe, but the noted ROM measurements were only mildly reduced and orthopedics did not recommend any additional treatment. In the absence of any significant functional deficits, there is no clear indication for additional PT rather than adherence to an independent home exercise program. In light of the above issues, the currently requested physical therapy is not medically necessary.