

<b>Case Number:</b>	CM14-0083239		
<b>Date Assigned:</b>	07/21/2014	<b>Date of Injury:</b>	08/11/2013
<b>Decision Date:</b>	10/01/2014	<b>UR Denial Date:</b>	05/16/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	06/04/2014

### 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 8/11/13. A utilization review determination dated 5/16/14 recommends non certification for the requested additional 6 sessions of physical therapy for the right shoulder. Non-certification was recommended since the patient had already exceeded the 8 week time window for therapy to be completed and patient should be directed to a home exercise program at this point. A progress report dated 3/19/14 includes subjective complaints of constant severe pain described as throbbing to the right shoulder. The pain was aggravated by lifting and overhead work. The patient also complained of throbbing and radiating pain from his right shoulder blade extending into his right elbow and wrist. Objective findings showed the patient to have 4+ spasm and tenderness to the right rotator cuff muscles and right upper shoulder muscles. Range of motion, measured by a goniometer, was limited and painful. Codmans test, speeds test and supraspinatus tests were all positive. Diagnostic impression was partial tear of the rotator cuff tendon of the right shoulder. Treatment plan at that time stated that the patient was taught a series of home exercises, physical therapy was requested, and a number of compound topical medications were prescribed as well as ibuprofen 800mg. MRI was ordered as well as a multi interferential stimulator. A follow up progress note dated 4/30/14 shows functional improvement from the 7 sessions of therapy with the patient being able to reach into higher shelving, the patient's pain being reduced from 5/10 to 3/10, and increased range of motion with shoulder flexion from 60 to 80 and extension from 25. The note indicates that the goals of the next sessions of physical therapy include improving the patient's activities of daily living, decreasing work restrictions, decreasing the need for medication, decreasing pain scores, decreasing swelling, and increasing active range of motion. The treatment plan recommends 6 additional physical therapy sessions and orthopedic surgeon consult due to a full thickness tear of the supraspinatous tendon identified by MRI.

## IMR ISSUES, DECISIONS AND RATIONALES

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

**Physical Therapy for the right shoulder 6 sessions:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Chronic Pain Treatment Guidelines Page(s): 99. Decision based on Non-MTUS Citation Official Disability Guidelines-Shoulder

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 200. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Shoulder Chapter, Physical Therapy

**Decision rationale:** Regarding the request for additional physical therapy, Chronic Pain Medical Treatment Guidelines recommend a short course of active therapy with continuation of active therapies at home as an extension of the treatment process in order to maintain improvement levels. ODG has more specific criteria for the ongoing use of physical therapy. ODG recommends a trial of physical therapy. If the trial of physical therapy results in objective functional improvement, as well as ongoing objective treatment goals, then additional therapy may be considered. ODG recommends 10 physical therapy visits for the treatment of shoulder impingement syndrome and rotator cuff disorders. Within the documentation available for review it is stated that the patient did indeed benefit from 7 physical therapy sessions and did have objective functional improvement but there is no statement indicating why an independent program of home exercise would be insufficient to address any remaining objective deficits. Additionally, the currently requested therapy, along with the previously provided visits, exceed the number of therapy sessions recommended by guidelines for this patient's diagnoses. As such, the currently requested additional Physical Therapy is not medically necessary.