

<b>Case Number:</b>	CM13-0029664		
<b>Date Assigned:</b>	11/01/2013	<b>Date of Injury:</b>	11/15/2012
<b>Decision Date:</b>	08/13/2015	<b>UR Denial Date:</b>	09/06/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	09/27/2013

### 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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:  
State(s) of Licensure: California, Texas, New Mexico  
Certification(s)/Specialty: Anesthesiology

### 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 52-year-old male patient who sustained an industrial injury on 11/15/2012. The patient was deemed permanent and stationary on 01/15/2015. At that time subjective complaints were of ongoing pain in the wrist. A recommendation was made to undergo a functional capacity evaluation. Back on 12/02/2014 at a follow up visit the chief complaint was right wrist pain. Current medications were: Biofreeze; Colace; pantoprazole, Terocin lotion, and Celebrex. The plan of care noted the following discontinued: Biofreeze, Terocin lotion, and Pantoprazole. The recommendation is to participate in a course of physical therapy, and was prescribed Celebrex, and Omeprazole. The patient is medically disabled.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**12 Physical Therapy Visits for the Right Shoulder (2) Times a Week for (6) Weeks as an Outpatient:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Work Loss Data Institute, Section; Shoulder.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 210, Chronic Pain Treatment Guidelines Physical Medicine Page(s): 98-99. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder- Physical Therapy.

**Decision rationale:** This is a review for the requested 12 physical therapy visits for the right shoulder two times a week for six weeks. According to the MTUS Guidelines, Physical Therapy is recommended and according to this patient's medical record there have already been six prior visits of physical therapy. After a six visit trial the patient should be formally assessed to see if the patient is moving in a positive direction prior to continuing physical therapy. There is no clear evidence of a formal assessment for improvement in function with physical therapy. In addition, this patient had previous physical therapy with the goal to allow for fading of treatment frequencies to an independent self-directed home exercise program. For these reasons, the above listed issue is considered NOT medically necessary.