

<b>Case Number:</b>	CM14-0187292		
<b>Date Assigned:</b>	11/17/2014	<b>Date of Injury:</b>	04/11/2012
<b>Decision Date:</b>	01/06/2015	<b>UR Denial Date:</b>	11/04/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	11/10/2014

### 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 Family Practice, and is licensed to practice in Mississippi and Texas. 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 55-year-old female who reported an injury on 03/20/2012. The mechanism of injury was not clearly provided. The injured worker's diagnoses include left adhesive capsulitis of the shoulder. The injured worker's past treatments included hot/cold packs, universal arm sling, physical therapy, and medications. There were no relevant diagnostic testing included in the documentation. The injured worker's surgical history included a left shoulder decompression. On 10/15/2014, the injured worker reported a dull, sharp pain moderate to severe, intermittent, worse with reaching overhead and improved with applying cold ice pack. She reported working modified duties. Upon physical examination, her grip strength testing was 20-20-20 pounds to the left hand and 35-40-45 pounds to the right hand. The anatomical alignment of the shoulder was well preserved. His shoulder range of motion was unrestricted in all planes. Rotator cuff strength was equal in both arms at 5/5. Impingement test, Neer's and Hawkin's test are negative. Sensation is intact to light touch, pinprick and 2 point discrimination in all dermatomes in the bilateral upper extremities. The request was for physical therapy 2 times a week for 4 weeks for the left shoulder. The injured worker's current medications were not included in the documentation. The rationale for the request was not clearly provided. A Request for Authorization form was signed and submitted on 10/15/2014.

### 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 4 weeks to the left shoulder:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 201-205. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder, Physical therapy

**Decision rationale:** The request for physical therapy 2 times a week for 4 weeks to the left shoulder is not medically necessary. According to the California MTUS/ACOEM Guidelines, pain relief is often the patient's first concern. Non-prescription analgesics may provide sufficient pain relief for most patients with acute and subacute symptoms. If treatment response is inadequate, prescribed pharmaceuticals or physical methods can be added. According to the Official Disability Guidelines, they may recommend treatment for adhesive capsulitis post surgically up to 24 visits over 14 weeks. When used alone, supervised physical therapy is a limited efficacy in the management of adhesive capsulitis. The documentation indicates the patient has completed physical therapy for the left shoulder. The number of sessions completed was not included in the documentation. The injured worker complains of continued moderate to severe pain to the left shoulder and was noted with decreased grip strength in the left shoulder. The documentation did not provide sufficient evidence of significant objective functional improvement with the completed physical therapy. In the absence of documentation with sufficient evidence of significant objective functional improvement, documented evidence of an objective decrease in pain as a result of the therapy, and the number of visits completed, the request is not supported. Therefore, the request is not medically necessary.