

<b>Case Number:</b>	CM14-0208608		
<b>Date Assigned:</b>	12/22/2014	<b>Date of Injury:</b>	10/08/2008
<b>Decision Date:</b>	02/13/2015	<b>UR Denial Date:</b>	11/12/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	12/12/2014

### 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 Rehab, has a subspecialty in Pain Medicine, 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:

The injured worker is a 55 year-old male with an original date of injury on 10/8/2008. The patient sustained an injury while he was lifting a table onto its opposite edge when it suddenly came straight down, straining the thoracic, lumbar region, and the right hand. The industrially related diagnoses are thoracic sprain / strain, lumbar disc injury, thoracic disc injury, status post left knee arthroscopic surgery, bilateral elbow pain, cervical radiculopathy, median neuropathy, and ulnar neuropathy. Prior treatments are physical therapy, steroid injections, home exercise program, heat and ice, and medications. The patient's medication regimen includes Norco, Mobic, Skelaxin, and Gabapentin. MRI of the right shoulder on 8/20/2009 showed that there was insertional tendinopathy of the supraspinatus, subacromial or subdeltoid bursitis, mild degenerative joint disease of the glenohumeral joint with spurring at the glenoid rim, with partial detachment of the posterior glenoid labrum. An electromyogram and nerve conduction study showed mild to moderate demyelinating ulnar neuropathies across bilateral elbows, and mild demyelinating sensorimotor generalized peripheral neuropathy. The disputed issue is the request for physical therapy to the right shoulder twice a week for 6 weeks, total of 12 sessions. A utilization review dated 11/12/2014 has modified this request to twice a week for 3 weeks, total of 6 sessions. The stated rationale for modification was the patient has previously had physical therapy to the right shoulder region with documented improvement. An additional 6 visits should be adequate to address any remaining deficit and be transitioned into home exercise program.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Physical therapy, 2 times weekly for 6 weeks, right shoulder, per 10/30/14 form:** Upheld

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

**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:** A progress note on 10/30/2014 indicated the patient continued to have shoulder region pain due to shoulder bursitis and underlying osteoarthritis. It was documented that the patient did feel improvement from previous physical therapy sessions, and he has regressed without physical therapy. There are multiple physical therapy sessions dated from 3/2014 to 7/2014. Regarding the request for 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. Within the documentation available for review, there is no statement indicating why an independent program of home exercise would be insufficient to address any objective deficits. Furthermore, the request exceeds the amount of physical therapy recommended by the CA MTUS, which recommends 10 visits over 8 weeks. In the absence of such documentation, the current request for physical therapy is not medically necessary.