

<b>Case Number:</b>	CM15-0019989		
<b>Date Assigned:</b>	02/09/2015	<b>Date of Injury:</b>	12/01/2003
<b>Decision Date:</b>	04/03/2015	<b>UR Denial Date:</b>	01/24/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	02/02/2015

### 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, Arizona

Certification(s)/Specialty: Physical Medicine & Rehabilitation

### 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 53-year-old male who reported an injury on 12/01/2013. The mechanism of injury was lifting. His diagnosis was noted as chronic impingement syndrome of the right shoulder, rule out rotator cuff tear, rule out glenoid labral tear, possible rupture along the head of the biceps tendon. His past treatments were noted to include medication, physical therapy, surgery and activity modification. During the assessment, on 11/26/2014, the injured worker was seen for chronic injuries to his right shoulders. It was noted that over the past several years, the injured worker had recurrent shoulder pain, swelling and catching. It was noted that he has not had recent treatment in the past several years. The injured worker complained of right shoulder pain exacerbated when attempting to performing lifting, reaching and pushing activities. He indicated that the pain occurred during the course of the day with occasional pain at night. The physical examination of the right shoulder revealed forward flexion of 160 degrees, abduction of 160 degrees, external rotation of 60 degrees and internal rotation to the T10 level. There was a positive Neer's, Hawkins and Jobe's test with tenderness at the subacromial bursa. There was tenderness noted at the acromioclavicular joint, with positive anterior and posterior acromioclavicular joint stress test. The treatment plan was to recommend an MRI of the right shoulder to evaluate the rotator cuff and labral tear, and supervised physical therapy. The rationale for the request was to initiate supervised physical therapy for modalities, range of motion and strengthening exercise. The Request for Authorization form was not submitted for review.

## IMR ISSUES, DECISIONS AND RATIONALES

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

**18 physical therapy visits:** Upheld

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

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

**Decision rationale:** The request for 18 physical therapy visits is not medically necessary. The California MTUS Guidelines note active therapy is based on the philosophy that therapeutic exercise and/or activity are beneficial for restoring flexibility, strength, endurance, function, range of motion and can alleviate discomfort. The guidelines recommend up to 10 visits over 8 weeks for myalgia and myositis, unspecified. The requested 18 visits would exceed guideline recommendation. There was a lack of adequate information regarding whether or not the injured worker had benefited from the past physical therapy visits or if there were any functional improvements made. Additionally, the number of completed physical therapy visits was not provided. Given the above, the request is not medically necessary.