

<b>Case Number:</b>	CM15-0149988		
<b>Date Assigned:</b>	08/13/2015	<b>Date of Injury:</b>	07/13/2011
<b>Decision Date:</b>	09/10/2015	<b>UR Denial Date:</b>	07/07/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	08/03/2015

### 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: Massachusetts

Certification(s)/Specialty: Physical Medicine & Rehabilitation, Pain Management

### 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 42 year old female, who sustained an industrial injury on July 13, 2011. She reported an injury to her neck and left shoulder and was diagnosed with cervical strain and left shoulder strain. Treatment to date has included left shoulder arthroscopy, physical therapy, steroid injection, diagnostic imaging, work modifications, home exercise program, heat therapy, and NSAIDS. Currently, the injured worker complains of constant pain of the left shoulder and limited range of motion. She reports headache due to pain and is unable to lift anything over three pounds. She rates her pain a 7 on a 10-point scale. The diagnoses associated with the request include other specified disorders of the bursae and tendons in the shoulder region and pain in the shoulder. The treatment plan includes twelve sessions of physical therapy for the left shoulder for muscle strength; range of motion and to improve the function of the left shoulder. She is instructed to use ice therapy as needed and she is to use Hydrocodone, Diclofenac Sodium, Tramadol, Cyclobenzaprine and Pantoprazole.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Physical therapy for the left shoulder 3 times a week for 4 weeks: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints, Chronic Pain Treatment Guidelines.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) (1) Chronic pain, Physical medicine treatment. (2) Preface, Physical Therapy Guidelines.

**Decision rationale:** The claimant sustained a work injury in July 2011 and underwent left shoulder arthroscopic surgery with a subacromial decompression in October 2013 followed by 24 postoperative physical therapy treatments. When seen, she was having left shoulder pain and headaches. She was having pain with range of motion. She reported being unable to lift more than 3 pounds. Authorization for 12 sessions of physical therapy was requested. The claimant is being treated for chronic pain with no new injury and has already had physical therapy consistent with the surgery that was performed. Patients are expected to continue active therapies and compliance with an independent exercise program would be expected without a need for ongoing skilled physical therapy oversight. An independent exercise program can be performed as often as needed/appropriate rather than during scheduled therapy visits. In terms of physical therapy treatment for chronic pain, guidelines recommend a six visit clinical trial with a formal reassessment prior to continuing therapy. In this case, the number of visits requested is in excess of that recommended or what might be needed to reestablish or revise the claimant's home exercise program which could include use of TheraBands and a home pulley system for strengthening and range of motion. Skilled therapy in excess of that necessary could promote dependence on therapy provided treatments. The request is not medically necessary.