

<b>Case Number:</b>	CM15-0160595		
<b>Date Assigned:</b>	08/27/2015	<b>Date of Injury:</b>	02/19/2015
<b>Decision Date:</b>	10/02/2015	<b>UR Denial Date:</b>	07/29/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	08/17/2015

### 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

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 48-year-old male who sustained an industrial injury on February 19, 2015 resulting in left thumb pain and bleeding, with subsequent left shoulder pain. Diagnosis is left shoulder tendonitis. Documented treatment for shoulder injury has been pain medication. A progress report dated July 16, 2015 indicates that the patient is complaining of left shoulder pain. Physical examination revealed some tenderness to the biceps tendon groove as well as the acromioclavicular point. Physical therapy is requested.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Left shoulder physical therapy 2x3 ( 6 visits): 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), Shoulder Chapter, 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:** 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 indication of any specific objective treatment goals and no statement indicating why an independent program of home exercise would be insufficient to address any objective deficits. Additionally, it does not appear that thorough physical examination has been performed in hopes of identifying a pain generator. There is no documentation of range of motion deficits, or testing to evaluate for rotator cuff tendinitis, impingement, or tears. This would be extremely helpful in giving the physical therapist some direction about what needs to be treated and precautions to take. In the absence of such documentation, the current request for physical therapy is not medically necessary.