

<b>Case Number:</b>	CM15-0164470		
<b>Date Assigned:</b>	09/01/2015	<b>Date of Injury:</b>	08/27/2014
<b>Decision Date:</b>	10/06/2015	<b>UR Denial Date:</b>	07/20/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	08/21/2015

### 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, District of Columbia, Maryland  
 Certification(s)/Specialty: Anesthesiology, 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 62 year old female, who sustained an industrial injury on 8-27-14. Initial complaints were not reviewed. The injured worker was diagnosed as having right wrist fractured distal radius-closed; right shoulder pain. Treatment to date has included physical therapy; medications. Diagnostics studies included MRI right shoulder (12-12-14). Currently, the PR-2 notes dated 7-6-15 indicated the injured worker was seen in this office for an orthopedic consultation. She has been treated for an industrial injury resulting in a right wrist fractured distal radius-closed reduction and right shoulder pain. She is in the office for a second opinion. She presents with no wrist pain and reports she has progressed with physical and occupational therapy. She notes continued stiffness and weakness however remarks improved greatly overall. She also notes decreasing right shoulder pain and decreasing stiffness due to the physical therapy and a previous steroid injection that provided moderate relief. On physical examination, the provider documents mild numbness and tingling in the hand but no swelling. She is currently working without restrictions. She is nontender throughout her hand, forearm and elbow and elbow range of motion is full without pain. A MRI of the right shoulder is documented for date of service 12-12-14 impression revealing minimal partial tearing and fraying affects the subscapularis. There are changes of tendinosis-tendinopathy of the supraspinatus. There is a small joint effusion present with a large amount of fluid in the subacromial=subdeltoid bursa. The components of the coracoacromial arch reveal a gradual curvature of the acromion where there is mild to moderate acromioclavicular joint arthropathy without significant deformity upon the supraspinatus muscle-tendon complex. An EMG-NCV study of the right upper extremity (no

date) is reported by the provider as no abnormalities. The provider is requesting authorization of Physical therapy 2 x 6 weeks for right shoulder.

### **IMR ISSUES, DECISIONS AND RATIONALES**

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

**Physical therapy 2 x 6 weeks for right shoulder:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine. Decision based on Non-MTUS Citation ACOEM Practice Guidelines, Chapter 6, Pain, Suffering and the Restoration of Function, page 113-114.

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

**Decision rationale:** Per MTUS CPMTG, physical medicine guidelines state: Allow for fading of treatment frequency (from up to 3 visits per week to 1 or less), plus active self-directed home Physical Medicine. Myalgia and myositis, unspecified (ICD9 729.1): 9-10 visits over 8 weeks. Neuralgia, neuritis, and radiculitis, unspecified (ICD 729.2): 8-10 visits over 4 weeks. The ODG Preface specifies Physical Therapy Guidelines, "There are a number of overall physical therapy philosophies that may not be specifically mentioned within each guideline: (1) As time goes by, one should see an increase in the active regimen of care, a decrease in the passive regimen of care, and a fading of treatment frequency; (2) The exclusive use of "passive care" (e.g., palliative modalities) is not recommended; (3) Home programs should be initiated with the first therapy session and must include ongoing assessments of compliance as well as upgrades to the program; (4) Use of self-directed home therapy will facilitate the fading of treatment frequency, from several visits per week at the initiation of therapy to much less towards the end; (5) Patients should be formally assessed after a "six-visit clinical trial" to see if the patient is moving in a positive direction, no direction, or a negative direction (prior to continuing with the physical therapy); & (6) When treatment duration and/or number of visits exceeds the guideline, exceptional factors should be noted." Per the ODG guidelines: Sprained shoulder; rotator cuff (ICD9 840; 840.4): Medical treatment: 10 visits over 8 weeks. Medical treatment, partial tear: 20 visits over 10 weeks. Post-surgical treatment (RC repair/acromioplasty): 24 visits over 14 weeks. Per the medical records submitted for review, the injured worker is currently working without restrictions. Additionally, the injured worker has completed 34 sessions of physical therapy for this injury as of 7/13/15. The request is not indicated, and the injured worker should have been transitioned to self-directed home therapy at this point. There is no mention of why a home exercise program is insufficient. The request is not medically necessary.