

<b>Case Number:</b>	CM15-0180794		
<b>Date Assigned:</b>	09/22/2015	<b>Date of Injury:</b>	08/23/2012
<b>Decision Date:</b>	11/03/2015	<b>UR Denial Date:</b>	08/21/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	09/14/2015

### 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

### 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 29 year old female, who sustained an industrial injury on 8-23-12. She is diagnosed with left shoulder-upper arm strain, left trapezius strain and left rotator cuff syndrome. Her work status is modified duty. A note dated 8-14-15 reveals the injured worker presented with complaints of tightness and spasms at the upper trapezius area. The pain is triggered by lifting, pushing and pulling. She has 50% impairment for general activities with her right arm and 75% for work activity, per "Quick DASH form". She also reports medium left shoulder pain described as aching and burning and is accompanied by numbness and tingling in her left hand and fingers. She rates her pain at 5 out of 10 and reports the pain is increased at night. She does report her shoulder is improving and feels it is 40-50% normal. A note dated 7-31-15 reveals complaints of intermittent left shoulder pain described as aching and burning and is rated at 6 out of 10. She reports pain relief from medications and not moving her shoulder. Physical examinations dated 6-16-15 - 8-14-15 revealed pain with lateral neck rotation to the right. There is pain to palpation in the left trapezius, paraspinals and directly over the lower cervical spine. The left shoulder examination revealed pain with motion in all planes, pain to palpation through the shoulder joint along with the left upper back, left trapezius and left paracervical neck. The range of motion is limited and there is decreased strength at 4 out of 5 and decreased left arm sensation, non-dermatomal and positive empty can test causes weakness and pain. Treatment to date has included rotator cuff repair, physical therapy (notes are difficult to decipher) and medication. Diagnostic studies to date have included MRI (2012) and electrodiagnostic studies (5-2015). A request for authorization dated 8-17-15 for physical therapy 2 times a week for 3 weeks for the left shoulder (6 sessions) is non-certified, per Utilization Review letter dated 8-21- 15.

## IMR ISSUES, DECISIONS AND RATIONALES

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

**Physical Therapy 2xWk x 3Wks for the Left Shoulder, Qty: 6: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Physical Medicine.

**Decision rationale:** Physical therapy is considered medically necessary when the services require the judgment, knowledge, and skills of a qualified physical therapist due to the complexity and sophistication of the therapy and the physical condition of the patient. However, there is no clear measurable evidence of progress with the PT treatment already rendered including milestones of increased ROM, strength, and functional capacity. Review of submitted physician reports show no evidence of functional benefit, unchanged chronic symptom complaints, clinical findings, and functional status. There is no evidence documenting functional baseline with clear goals to be reached and the patient striving to reach those goals. The Chronic Pain Guidelines allow for visits of physical therapy with fading of treatment to an independent self-directed home program. It appears the employee has received significant therapy sessions without demonstrated evidence of functional improvement to allow for additional therapy treatments. There is no report of acute flare-up, new injuries, or change in symptom or clinical findings to support for formal PT in a patient that has been instructed on a home exercise program for this chronic 2012 injury. Submitted reports have not adequately demonstrated the indication to support further physical therapy when prior treatment rendered has not resulted in any functional benefit. The physical therapy 2xWk x 3Wks for the left shoulder, Qty: 6 is not medically necessary or appropriate.