

<b>Case Number:</b>	CM15-0197430		
<b>Date Assigned:</b>	10/13/2015	<b>Date of Injury:</b>	07/30/2014
<b>Decision Date:</b>	11/20/2015	<b>UR Denial Date:</b>	09/11/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/07/2015

### 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 64 year old female who sustained an industrial injury July 30, 2014. Diagnoses are right shoulder, partial tear of the supraspinatus tendon with impingement; right biceps tendinitis; right elbow, lateral epicondylitis; right wrist thumb, deQuervain's tenosynovitis. According to a physical therapist notes dated August 20, 2015, the injured worker presented for visit #18. She reported experiencing a lot of pain in her right upper arm, which is limiting her using the right upper arm on a consistent basis. She does not feel any significant change in her right shoulder mobility or function since her last progress report dated July 15, 2015. She has completed her (8) additional therapy sessions and is reporting high levels of pain and a lack of functional progress. According to a primary treating physician's progress report dated August 31, 2015, the injured worker presented for re-evaluation of the right shoulder, right arm including elbow and wrist and right thumb. She reports continued pain across the right shoulder to the right biceps muscle and mild pain in the right elbow. She reports her right wrist, hand and thumb are doing significantly well. Objective findings included; right shoulder- well healed surgical scars; mild swelling, tenderness of the AC (acromioclavicular) joint, biceps tendon, Apley's scratch test positive, Neer's positive, Hawkins and Speed's positive; right wrist and thumb- tenderness over the first extensor compartment, Finkelstein's positive, full range of motion of thumb, pain with ulnar deviation; right elbow-point tenderness over the lateral condyle, pain with resisted supination and pronation, compartments soft; normal sensation to all dermatomes. Treatment plan included continue with medication, continue home exercise physical therapy program and at issue, a request for authorization dated September 3, 2015, for physical therapy for the right shoulder. According to utilization review dated September 11, 2015, the request for (12) physical therapy sessions for the right shoulder (3 x 4) weeks as an outpatient is non-certified.

## IMR ISSUES, DECISIONS AND RATIONALES

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

### **Physical therapy 3x a week for 4 weeks for the right shoulder (12): Upheld**

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

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

**Decision rationale:** Per physical therapy report in August 2015, the patient has completed 18 PT visits to date. Time-limited care plan with specific defined goals, assessment of functional benefit with modification of ongoing treatment based upon the patient's progress in meeting those goals and the provider's continued monitoring of successful outcome is stressed by MTUS guidelines. 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. Submitted reports have no acute flare-up or specific physical limitations to support for physical/ occupational therapy. The Chronic Pain Guidelines allow for 9-10 visits of therapy with fading of treatment to an independent self-directed home program. It is unclear how many PT sessions have been completed; however, the submitted reports have not identified clear specific functional improvement in ADLs, functional status, or decrease in medication and medical utilization nor have there been a change in neurological compromise or red-flag findings demonstrated from the formal physical therapy already rendered to support further treatment. Submitted reports have also not adequately demonstrated the indication to support for excessive quantity of PT sessions without extenuating circumstances established beyond the guidelines. The physical therapy 3x a week for 4 weeks for the right shoulder (12) is not medically necessary and appropriate.