

<b>Case Number:</b>	CM15-0215855		
<b>Date Assigned:</b>	11/05/2015	<b>Date of Injury:</b>	05/14/2005
<b>Decision Date:</b>	12/18/2015	<b>UR Denial Date:</b>	10/08/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	11/03/2015

### 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: California, Indiana, New York  
 Certification(s)/Specialty: Internal Medicine

### 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 56 year old male worker who sustained an industrial injury on May 14, 2005. Of note, the worker has not worked since 2006. The worker is being treated for: chronic right shoulder pain with history of previous arthroscopy and acromioplasty with noted complication of surgery resulted in permanent blindness and subsequent left ankle sprain and strain; left ankle joint painful joint capsulitis. Subjective: September 02, 2015 he reported left foot and ankle pain. September 11, 2015 he reported complaint of right shoulder pain, and gastric upset. Objective: September 02, 2015 noted the left foot and ankle with mild chronic swelling at the anterolateral left ankle joint. There is good ROM with no significant crepitus or limitation. September 11, 2015 noted ROM restricted to right shoulder; "mild pain noted with palpation over the anterior lateral aspect of the shoulder. There are noted positive impingement signs and noted shoulder joint instability. Diagnostic: radiographic study, shoulder and MRI, left ankle. Medication: September 11, 2015: Norco. Prescribed September 22, 2015: Bupropion, Tylenol, Ambien CR, and Xanax. Treatment: Initial treatment noted wound care, physical therapy treatment and ultimately surgical intervention of the right shoulder 2006; since surgery the worker noted receiving flare up treatment to include: physical therapy session(s), medications, massage therapy, and reflexology therapy. September 11, 2015 noted a prescription written for course of physical therapy to evaluate and treat, therapeutic exercise, ROM, stretching and strengthening protocol, psychological evaluation and treatment, unskilled home help. On October 01, 2015 a request was made for outpatient physical therapy 12 sessions to the right shoulder that was noncertified by Utilization Review on October 08, 2015.

## IMR ISSUES, DECISIONS AND RATIONALES

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

**Outpatient physical therapy to right shoulder 2 times a week for 6 weeks: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Physical Medicine. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder section, Physical therapy.

**Decision rationale:** Pursuant to the Chronic Pain Medical Treatment Guidelines and the Official Disability Guidelines, outpatient physical therapy to the right shoulder two times per week times six weeks is not medically necessary. 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 negative direction (prior to continuing with physical therapy). When treatment duration and/or number of visits exceeds the guideline, exceptional factors should be noted. In this case, the injured worker's working diagnosis is chronic right shoulder pain with history previous arthroscopy and acromioplasty. Date of injury is May 14, 2005. Request for authorization is dated October 1, 2015. According to a September 11, 2015 progress note, the worker's status post right shoulder arthroscopy July 31, 2006. The injured worker has ongoing chronic pain. The injured worker has received intermittent treatment with physical therapy over the years in addition to massage therapy and medications. Subjectively, pain score is 10/10 all the time. Objectively, there is tenderness to palpation over the anterior lateral shoulder. There is positive impingement. The total number of physical therapy sessions from surgery through the present is not specified in the record. There is no documentation demonstrating objective functional improvement. There are no compelling clinical facts indicating additional physical therapy over the recommended guidelines is clinically indicated. There is no documentation of an ongoing home exercise program. Based on clinical information in the medical record, peer-reviewed evidence-based guidelines, no documentation indicating total number of physical therapy sessions to date, no documentation demonstrating objective functional improvement, and no compelling clinical facts indicating additional physical therapy over the recommended guidelines is indicated for ongoing chronic pain, outpatient physical therapy to the right shoulder two times per week times six weeks is not medically necessary.