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| <b>Case Number:</b>   | CM15-0046859 |                              |            |
| <b>Date Assigned:</b> | 03/19/2015   | <b>Date of Injury:</b>       | 08/27/2011 |
| <b>Decision Date:</b> | 05/01/2015   | <b>UR Denial Date:</b>       | 03/09/2015 |
| <b>Priority:</b>      | Standard     | <b>Application Received:</b> | 03/12/2015 |

### 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 47-year-old female injured worker suffered an industrial injury on 8/27/2011. The diagnoses were right shoulder internal derangement, rotator cuff tear, impingement syndrome, and sprain/strain, bilateral carpal tunnel syndrome and lumbar sprain/strain. The treatments were medications and TENS unit. The treating provider reported right wrist and shoulder pain. On exam, there was tenderness of the right shoulder right wrist and lumbar muscles. The lumbar spine had reduced range of motion. In addition, there was left shoulder impingement syndrome and tendinitis with reduced range of motion. The requested treatments were: 1. 12 sessions of physical therapy to the left shoulder. 2. X-ray anteroposterior (AP) lateral for left shoulder.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**12 sessions of physical therapy to the left shoulder:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Chapter.

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

**Decision rationale:** The patient was injured on 08/27/11 and presents with right wrist pain and right shoulder pain. The request is for 12 SESSIONS OF PHYSICAL THERAPY TO THE LEFT SHOULDER to improve her range of motion, function, and strength. There is no RFA provided and patient is on temporary total disability. Review of the reports provided does not indicate if the patient has had any prior physical therapy. MTUS page 98 and 99 has the following: "Physical medicine: Recommended as indicated below. Allow for fading of treatment frequency (from up to 3 visits per week to 1 or less), plus active self-directed home physical medicine." MTUS Guidelines page 98 and 99 states that for myalgia and myositis, 9 to 10 visits are recommended over 8 weeks, and for neuralgia, neuritis, radiculitis, 8 to 10 visits are recommended. There is no documentation of any recent physical therapy or any recent surgery she may have had either. She is diagnosed with impingement syndrome of the right and left shoulder, wrist joint inflammation, carpal tunnel syndrome on the right, and stresses/depression. In this case, the treater is requesting for 12 visits of physical therapy, which exceeds what MTUS Guidelines allow. Therefore, the requested physical therapy IS NOT medically necessary.

**X-ray anteroposterior (AP) lateral for left shoulder:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official disability guidelines Shoulder chapter, Radiography.

**Decision rationale:** The patient was injured on 08/27/11 and presents with right wrist pain and right shoulder pain. The request is for X-RAY ANTEROPOSTERIOR (AP) LATERAL FOR LEFT SHOULDER. There is no RFA provided and patient is on temporary total disability. Review of the reports provided does not indicate if the patient has had any prior x-ray for the left shoulder. Regarding radiography of the shoulder, ODG states "Recommended" when there an indication of acute shoulder trauma to rule out fracture or dislocation and questionable bursitis, blood calcium (Ca+)/approximately 3 months duration. Review of the provided reports show no evidence of prior X-ray of the shoulder. There is no indication that the patient has an acute shoulder trauma to rule out fracture, dislocation or questionable bursitis. Exam of the shoulders were not included in the review. In this case, the treating physician provided no documentation to indicate that the patient has an acute shoulder trauma to warrant an imaging study of the left shoulder. Therefore, the requested x-ray of the left shoulder IS NOT medically necessary.