

<b>Case Number:</b>	CM14-0215555		
<b>Date Assigned:</b>	01/05/2015	<b>Date of Injury:</b>	08/05/2014
<b>Decision Date:</b>	02/24/2015	<b>UR Denial Date:</b>	11/24/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	12/23/2014

### 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: Iowa, Illinois, Hawaii

Certification(s)/Specialty: Preventive Medicine, Occupational Medicine, Public Health & Gen Prev Med

### CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

This patient is a 54 year old employee with date of injury of 8/5/14. Medical records indicate the patient is undergoing treatment for rotator cuff sprain. Subjective complaints include loss of strength and pain in right shoulder. Objective findings include impingement sign positive in full elevation; range of motion in the right shoulder (in degrees): elevation, 150; external rotation, 60 and internal rotation, 12. Treatment has consisted of 14 sessions of physical therapy, home exercise, Ibuprofen and a subacromial injection. The utilization review determination was rendered on 11/24/14 recommending non-certification of four sessions of physical therapy to the right shoulder.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Four sessions of physical therapy for the right shoulder:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 48, 98-99.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 196-219, Chronic Pain Treatment Guidelines Physical Therapy, Physical Medicine

Page(s): 98-99, Postsurgical Treatment Guidelines Page(s): 26-27. Decision based on Non-MTUS Citation Shoulder (Acute & Chronic), Physical therapy

**Decision rationale:** California MTUS guidelines refer to physical medicine guidelines for physical therapy, "Allow for fading of treatment frequency (from up to 3 visits per week to 1 or less), plus active self-directed home Physical Medicine." Regarding physical therapy, ODG states "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); and when treatment duration and/or number of visits exceeds the guideline, exceptional factors should be noted. At the conclusion of this trial, additional treatment would be assessed based upon documented objective, functional improvement, and appropriate goals for the additional treatment. The treating physician does not document the specific functional improvements made from the prior physical therapy sessions. As such, the request for four physical therapy sessions to the right shoulder is not medically necessary.