

<b>Case Number:</b>	CM15-0123450		
<b>Date Assigned:</b>	07/07/2015	<b>Date of Injury:</b>	04/15/2014
<b>Decision Date:</b>	08/04/2015	<b>UR Denial Date:</b>	06/16/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	06/26/2015

### 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: Massachusetts

Certification(s)/Specialty: Physical Medicine & Rehabilitation, Pain Management

### 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 47 year old female who sustained an industrial injury on 4/15/14 from repetitious work tasks resulting in right shoulder pain initially but left shoulder flared due to compensation. She was medically evaluated, received medications and activity modification and eventually had a right shoulder scope with subacromial decompression and manipulation (9/2014). She continued to complain of pain, locking and numbness of the right upper extremity. She currently complains of achy left shoulder pain with a pain level of 8/10. On physical exam there was tenderness on palpation right and left shoulder region. Medications were not specifically identified. Diagnoses include right shoulder adhesive capsulitis, status post right shoulder arthroscopy with subacromial decompression and manipulation (9/5/14); left shoulder partial tear long head biceps tendon/ rotator cuff. Treatments to date include physical therapy. Diagnostics include MRI of the right shoulder (7/18/14) showing mild joint effusion, full thickness rotator cuff tear, tendinitis, acromioclavicular degenerative disease. In the progress note dated 5/19/15 the treating provider's plan of care included a request for physical therapy for range of motion overpressure program focusing on improving range of motion and incorporating high frequency-low intensity home program. Prior physical therapy notes indicate that the injured worker cannot get past 90 degrees. On 6/15/15 utilization Review evaluated a request for physical therapy twice per week for six weeks to bilateral shoulders.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Physical therapy 2 x 6 bilateral shoulders:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Physical medicine, Postsurgical Treatment Guidelines.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) (1) Chronic pain, Physical medicine treatment. (2) Preface, Physical Therapy Guidelines.

**Decision rationale:** The claimant has a history of a work related repetitive strain injury with date of injury in April 2014 and continues to be treated for right shoulder pain. She underwent a subacromial decompression with manipulation in September 2014. When seen, she had completed more than 30 postoperative physical therapy treatments. She was having shoulder pain rated at 8/10. There was decreased range of motion and strength with rotator cuff tenderness. The claimant is being treated for chronic pain with no new injury and has already had physical therapy. Patients are expected to continue active therapies and compliance with an independent exercise program would be expected without a need for ongoing skilled physical therapy oversight. An independent exercise program can be performed as often as needed/ appropriate rather than during scheduled therapy visits and in this case could include use of TheraBands and a home pulley system for strengthening and range of motion. In terms of physical therapy treatment for chronic pain, guidelines recommend a six visit clinical trial with a formal reassessment prior to continuing therapy. In this case, the number of visits requested is in excess of that recommended or what might be needed to reestablish or revise a home exercise program. The request is not medically necessary.