

<b>Case Number:</b>	CM15-0128445		
<b>Date Assigned:</b>	07/15/2015	<b>Date of Injury:</b>	02/13/2015
<b>Decision Date:</b>	08/19/2015	<b>UR Denial Date:</b>	06/02/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	07/03/2015

### 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: Pennsylvania, Ohio, 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 46-year-old male, who sustained an industrial injury on 2/13/2015. The mechanism of injury was a fall. The injured worker was diagnosed as having left shoulder sprain/strain and quadriceps contusion. There is no record of a recent diagnostic study. Treatment to date has included therapy and medication management. In a progress note dated 4/23/2015, the injured worker complains of pain in the right and left shoulder, rated 4/10. Physical examination showed right shoulder tenderness and decreased range of motion. The treating physician is requesting 12 visits of physical therapy for the right knee and left shoulder.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Physical Therapy 3x4 for the right knee and left shoulder:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints, Chapter 13 Knee Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Shoulder, Physical Therapy; Knee & Leg, Physical Therapy.

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

**Decision rationale:** MTUS encourages physical therapy with an emphasis on active forms of treatment and patient education. This guideline recommends transition from supervised therapy to active independent home rehabilitation. Given the timeline of this injury and past treatment, the patient would be anticipated to have previously transitioned to such an independent home rehabilitation program. The records do not provide a rationale at this time for additional supervised rather than independent rehabilitation. This request is not medically necessary.