

<b>Case Number:</b>	CM15-0128697		
<b>Date Assigned:</b>	07/15/2015	<b>Date of Injury:</b>	05/07/2014
<b>Decision Date:</b>	08/10/2015	<b>UR Denial Date:</b>	06/25/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	07/02/2015

### 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 injured worker is a 66 year old male, who sustained an industrial injury on May 7, 2014. He reported injury to his right shoulder. The injured worker was diagnosed as having pain in joint shoulder and sprain/strain rotator cuff. Treatment to date has included diagnostic studies, surgery, physical therapy and medications. On June 11, 2015, the injured worker stated that he only feels pain when he reaches out to far or tries to pull something. The pain was described as intermittent with those movements. The treatment plan included option of surgery for repair of torn rotator cuff, eight sessions of physical therapy, shoulder injection and medications. On June 25, 2015, Utilization Review non-certified the request for physical therapy two times a week for four weeks for the right shoulder, citing California MTUS Guidelines.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**PT 2x4 Right Shoulder:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Physical Therapy, pages 98-99.

**Decision rationale:** Submitted reports have no acute flare-up or specific physical limitations to support for physical/ occupational therapy. Therapy is considered medically necessary when the services require the judgment, knowledge, and skills of a qualified physical therapist due to the complexity and sophistication of the therapy and the physical condition of the patient. Submitted reports have no new injury or specific neurological deficit progression to support for physical/ occupational therapy. The Chronic Pain Guidelines allow for 9-10 visits of therapy with fading of treatment to an independent self-directed home program. It appears the patient has received prior sessions of PT/OT without clear specific functional improvement in ADLs, functional status, or decrease in medication and utilization without change in neurological compromise or red-flag findings to support further treatment. The PT 2x4 Right Shoulder is not medically necessary and appropriate.