Case Number:	CM15-0175430		
Date Assigned:	09/16/2015	**Date of Injury:**	02/03/2015
Decision Date:	10/19/2015	**UR Denial Date:**	08/07/2015
Priority:	Standard	**Application Received:**	09/04/2015

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: North Carolina
Certification(s)/Specialty: Family Practice

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 37 year old male who sustained an industrial injury on 02-03-2015. Mechanism of injury was a fall. Diagnoses include left rotator cuff tear, left shoulder impingement syndrome, left shoulder pain, left shoulder sprain-stain, left interphalangeal joint and left hand joint pain. A physician progress note dated 07-31-2015 documents the injured worker complains of occasional mild left shoulder pain and tingling associated with prolonged reaching, grabbing grasping, gripping and squeezing. He did have relief with acupuncture and physical therapy. Left shoulder range of motion is restricted with flexion and abduction, and painful. He complains of activity-dependent mild to 2 out of 10 left hand pain and stiffness associated with movement. There is tenderness to palpation of the acromioclavicular joint, anterior shoulder, glenohumeral joint, lateral shoulder, posterior shoulder and supraspinatus. Supraspinatus Press is positive. As of 07-31-2015, the injured worker has received 13 physical therapy visits and 14 acupuncture sessions to date. On 07-14-2015, the injured worker was prescribed compounded topical creams, and a Urine Drug Screen was done. On 07-09-2015 a physician progress note documents the injured worker complains of occasional mild left shoulder pain and tingling associated with prolonged reaching, grabbing grasping, gripping and squeezing. He did have relief with acupuncture and physical therapy. Left shoulder range of motion is restricted with flexion and abduction, and painful. He complains of activity-dependent mild to 2 out of f10 left hand pain and stiffness associated with movement. There is tenderness to palpation of the acromioclavicular joint, anterior shoulder, glenohumeral joint, lateral shoulder, posterior shoulder and supraspinatus. Supraspinatus Press is positive. Treatment to date has

included diagnostic studies, compounded topical creams, physical therapy visits, and acupuncture. A Magnetic Resonance Imaging of the left shoulder done on 03-03-2015 revealed bone contusion- marrow edema involving the posterior superior humeral head and mild Hill-Sachs lesion suggesting history of anterior shoulder dislocation, full-thickness tear along the superior posterior labrum, partial thickness articular surface tears and tendinosis of the infraspinatus tendon as well as partial thickness tears of the anterior most aspect supraspinatus footplate. Round 10mm lesion demonstrating partial fluid signal as well as bone marrow signal within the humeral neck. Differential considerations could include prior posterior osteoma, complex bone cyst, enostosis or other lesions. On 08-07-2015 the Utilization Review non-certified the request for 12 physical therapy sessions for the left shoulder.

IMR ISSUES, DECISIONS AND RATIONALES

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

12 Physical Therapy Sessions for the Left Shoulder: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Physical Medicine.

Decision rationale: The California chronic pain medical treatment guidelines section on physical medicine states: Recommended as indicated below. Passive therapy (those treatment modalities that do not require energy expenditure on the part of the patient) can provide short-term relief during the early phases of pain treatment and are directed at controlling symptoms such as pain, inflammation and swelling and to improve the rate of healing soft tissue injuries. They can be used sparingly with active therapies to help control swelling, pain and inflammation during the rehabilitation process. Active therapy is based on the philosophy that therapeutic exercise and/or activity are beneficial for restoring flexibility, strength, endurance, function, range of motion, and can alleviate discomfort. Active therapy requires an internal effort by the individual to complete a specific exercise or task. This form of therapy may require supervision from a therapist or medical provider such as verbal, visual and/or tactile instruction(s). Patients are instructed and expected to continue active therapies at home as an extension of the treatment process in order to maintain improvement levels. Home exercise can include exercise with or without mechanical assistance or resistance and functional activities with assistive devices. (Colorado, 2002) (Airaksinen, 2006) Patient-specific hand therapy is very important in reducing swelling, decreasing pain, and improving range of motion in CRPS. (Li, 2005) The use of active treatment modalities (e.g., exercise, education, activity modification) instead of passive treatments is associated with substantially better clinical outcomes. In a large case series of patients with low back pain treated by physical therapists, those adhering to guidelines for active rather than passive treatments incurred fewer treatment visits, cost less, and had less pain and less disability. The overall success rates were 64.7% among those adhering to the active treatment recommendations versus 36.5% for passive treatment. (Fritz, 2007)Physical Medicine Guidelines: Allow for fading of treatment frequency (from up to 3 visits per week to 1 or less), plus active self-directed home Physical Medicine. Myalgia and myositis, unspecified

(ICD9 729.1): 9-10 visits over 8 weeks. Neuralgia, neuritis, and radiculitis, unspecified (ICD9 729.2) 8-10 visits over 4 weeks. Reflex sympathetic dystrophy (CRPS) (ICD9 337.2):24 visits over 16 weeks. The requested amount of physical therapy is in excess of California chronic pain medical treatment guidelines. The patient has already completed a course of physical therapy. There is no objective explanation why the patient would need excess physical therapy and not be transitioned to active self-directed physical medicine. The request is not medically necessary.