

<b>Case Number:</b>	CM15-0177873		
<b>Date Assigned:</b>	09/18/2015	<b>Date of Injury:</b>	07/05/2011
<b>Decision Date:</b>	10/21/2015	<b>UR Denial Date:</b>	09/02/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	09/09/2015

### 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:

This injured worker is a 40 year old male, who sustained an industrial injury on 07-05-2011. The injured worker was diagnosed as having right shoulder pain-possible rotator cuff tendinitis. On medical records dated 08-25-2015 and 06-30-2015, subjective complaints were noted as right shoulder pain. Objective findings on 08-25-2015 were noted as right shoulder pain on palpation of the subacromial space as well as distal supraspinatus. Pain was noted to increase with attempt to abduct and elevate the arm above the horizontal with report discomfort in the superior and posterolateral aspect of the shoulder. The injured worker was noted to be temporary totally disabled. Treatment to date included medication. Current medication was listed as Mirtazapine, Abilify, Risperdone, Ibuprofen and Nabumetone. The Utilization Review (UR) was dated 09-02-2015. The UR submitted for this medical review indicated that the request for physical therapy 2xwk x 4wks, right shoulder was non-certified.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Physical therapy 2xwk x 4wks, Right shoulder:** Overturned

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

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder (Acute & Chronic), physical therapy.

**Decision rationale:** The claimant sustained a work injury in July 2011 and continues to be treated for right shoulder pain and weakness. In July 2015 he had symptoms especially with overhead use. He had decreased active forward flexion. There was mild discomfort with supraspinatus testing. Impingement testing was mildly positive. His body mass index was nearly 38. Authorization for a course of physical therapy was requested. The facility requested is named "MORE Physical therapy." In terms of physical therapy for rotator cuff impingement syndrome, guidelines recommend up to 10 treatment sessions over 8 weeks. In this case, the number of initial visits requested is within the guideline recommendation. There is no evidence that the claimant has actually participated in therapy treatments for his shoulder condition. The request is medically necessary.