

<b>Case Number:</b>	CM13-0002695		
<b>Date Assigned:</b>	07/02/2014	<b>Date of Injury:</b>	12/08/2009
<b>Decision Date:</b>	10/20/2014	<b>UR Denial Date:</b>	07/02/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	07/23/2013

### 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. The expert reviewer is Board Certified in Occupational Medicine and is licensed to practice in California. 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

### 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 physical therapy two times a week for four weeks for the right shoulder was modified to just four additional sessions. Per the records provided, the diagnosis was a February 11, 2013 right shoulder surgery for subacromial decompression and cervical and lumbar degenerative disc disease. The injury occurred about 3 1/2 years ago. At the time of this request, the claimant was two months post operation. There have been 20 postoperative physical therapy sessions. There was improved range of motion, but it is not clear if any other functional benefit was being derived from the physical therapy. The guidelines would support about 24 sessions postoperative as for the ODG. Therefore, about four additional sessions would be appropriate. There were other requests for tramadol, naproxen and pantoprazole and cyclobenzaprine. The application for independent medical review was signed on July 15, 2014. The surgery was 2-11-13 for the right shoulder. Care was at [REDACTED]. As of March 5, 2013, the recommendation was for 12 sessions of physical therapy. The patient was status post a right shoulder arthroscopic subacromial decompression and distal trachelectomy. The wounds were healing well with minimal discomfort. Range of motion demonstrates 80 of abduction and flexion. There was no mention it was an open procedure, or there were comorbidities to drive a need for more than usual care.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Physical Therapy 2x4 Right Shoulder:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Postsurgical Treatment Guidelines.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines 8 C.C.R. 9792.20 -9792.26 Page(s): 98. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder section, under PT for the shoulder post arthroscopy.

**Decision rationale:** The ODG notes in the shoulder physical therapy sessions that 24 post-operative sessions are supported for an arthroscopy. The MTUS does permit physical therapy in chronic situations, noting that one should allow for fading of treatment frequency (from up to 3 visits per week to 1 or less), plus active self-directed home Physical Medicine. The conditions mentioned are 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; and Reflex sympathetic dystrophy (CRPS) (ICD9 337.2): 24 visits over 16 weeks. This claimant does not have these conditions. After several documented sessions of therapy, it is not clear why the patient would not be independent with self-care at this point. Also, there are especially strong caveats in the MTUS/ACOEM guidelines against over treatment in the chronic situation supporting the clinical notion that the move to independence and an active, independent home program is clinically in the best interest of the patient. They cite 1. Although mistreating or under treating pain is of concern, an even greater risk for the physician is over treating the chronic pain patient. Over treatment often results in irreparable harm to the patient's socioeconomic status, home life, personal relationships, and quality of life in general. 2. A patient's complaints of pain should be acknowledged. Patient and clinician should remain focused on the ultimate goal of rehabilitation leading to optimal functional recovery, decreased healthcare utilization, and maximal self actualization. This request for the 12 sessions of post surgical therapy is not medically necessary.