

<b>Case Number:</b>	CM13-0009727		
<b>Date Assigned:</b>	03/03/2014	<b>Date of Injury:</b>	12/18/2012
<b>Decision Date:</b>	04/23/2014	<b>UR Denial Date:</b>	08/01/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	08/12/2013

### 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 Physical Medicine and Rehabilitation, has a subspecialty in Sports Medicine and is licensed to practice in Texas. 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 patient is a female who reported an injury on 12/18/2002. The patients date of birth or mechanism of injury were not provided in the medical records. The patient was diagnosed with left shoulder greater tuberosity fracture with partial rotator cuff tear. Physical examination of the shoulder revealed a flexion of 165 degrees, abduction 160 degrees, hand behind the back measured with the thumb to the level of L2, and external rotation of 60 degrees.

### IMR ISSUES, DECISIONS AND RATIONALES

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

#### **SHOULDER REHAB PROGRAM TWO TIMES FOUR WEEKS QUANTITY EIGHT:**

Upheld

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

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

**Decision rationale:** According to the California Guidelines, physical therapy allows for fading of treatment frequency (from up to 3 visits per week to 1 or less), plus active self-directed home physical medicine and the conditions of myalgia and myositis, unspecified, at 9 to 10 visits. The most recent clinical note provided indicated the patient had improved functional range of motion

of the shoulder. It was also noted that the patient had completed at least 8 physical therapy sessions. In the absence of documented exceptional factors and details regarding functional deficits, additional therapy is not supported. Therefore, the request for shoulder rehab program 2x4 weeks, quantity 8, is non-certified.