

<b>Case Number:</b>	CM13-0026171		
<b>Date Assigned:</b>	05/21/2014	<b>Date of Injury:</b>	11/16/2011
<b>Decision Date:</b>	07/23/2014	<b>UR Denial Date:</b>	08/13/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	09/19/2013

### 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 Orthopedic and Hand Surgery 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 injured worker is a 45-year-old female who reported an injury on 11/16/2011. The mechanism of injury was not provided within the medical records. The clinical note dated 01/23/2014 indicated diagnoses of status post right shoulder surgery on 03/07/2013, and inflammatory process of the shoulder with stiff shoulder syndrome, rule out internal derangement. The injured worker reported dull to sharp pain in the right shoulder, occurring constantly. On physical examination, there was tenderness to palpation with decreased range of motion. The injured worker's prior treatments included diagnostic imaging, physical therapy, surgery, and medication management. The provider submitted a request for physical therapy 1 time per week for 6 weeks. A request for authorization was not submitted for review to include the date the treatment was requested.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**PHYSICAL THERAPY 1 TIME PER WEEK FOR 6 WEEKS FOR RIGHT SHOULDER:**  
Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Postsurgical Treatment Guidelines.

**Decision rationale:** The request for PHYSICAL THERAPY 1 TIME PER WEEK FOR 6 WEEKS STATUS POST RIGHT SHOULDER is not medically necessary. The California MTUS guidelines state that 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. The guidelines note injured workers are instructed and expected to continue active therapies at home as an extension of the treatment process in order to maintain improvement levels. There was a lack of documentation including an adequate and complete physical exam demonstrating the injured worker has decreased functional ability, decreased range of motion, and decreased strength or flexibility. In addition, the amount of physical therapy visits that have already been completed for the right shoulder was not submitted for review. However, documentation submitted did indicate the injured worker completed postop physical therapy. The completed physical therapy should have been adequate to improve functionality and transition the injured worker to a home exercise program where the injured worker may continue with exercises such as strengthening, stretching, and range of motion. Therefore, the request for physical therapy 1 time per week is not medically necessary.