

<b>Case Number:</b>	CM13-0037748		
<b>Date Assigned:</b>	12/18/2013	<b>Date of Injury:</b>	07/14/2011
<b>Decision Date:</b>	03/05/2014	<b>UR Denial Date:</b>	10/11/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/24/2013

### HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Internal 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 physician 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 55-year-old female who reported an injury on 07/14/2011. The patient is currently diagnosed with right shoulder rotator cuff tear and right shoulder degenerative joint disease. The patient is status post right reverse total shoulder on 10/31/2012. The patient was seen by [REDACTED] on 07/26/2013. The patient has been receiving physical therapy and is currently taking pain medication. Physical examination revealed marked limitation of motion with intact sensation and negative edema. Treatment recommendations included continuation of physical therapy times 8 more sessions.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Physical therapy therapeutic exercises, manual therapy, HP/CP, and re-evaluation x6 visits:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation ODG- TWC Pain Procedure Summary

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Manual Therapy & Manipulation, Physical Medicine Page(s): 58, 98-99.

**Decision rationale:** The MTUS Chronic Pain Guidelines state 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. Patients are instructed and expected to continue active therapy at home as an extension of the treatment process. Guidelines allow for a fading of treatment frequency plus active self-directed home physical medicine. As per the clinical notes submitted, the patient is status post right shoulder reverse total arthropathy on 10/31/2012. The patient has completed a previous course of postoperative physical therapy. However, the patient continues to report persistent pain with significant loss of range of motion. Documentation of the previous course of postoperative physical therapy with treatment duration and treatment efficacy was not provided within the medical records submitted for review. Without significant and validated improvement, the medical necessity of ongoing physical therapy has not been established. Therefore, the request is not medically necessary and appropriate.