

<b>Case Number:</b>	CM13-0040549		
<b>Date Assigned:</b>	12/20/2013	<b>Date of Injury:</b>	04/28/2008
<b>Decision Date:</b>	03/20/2014	<b>UR Denial Date:</b>	10/01/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/29/2013

### 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 Physical Medicine and Rehabilitation 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 63-year-old male who reported an injury on 04/28/2008, secondary to a fall. The patient is currently diagnosed with a sprained shoulder. The only recent documentation submitted for this review includes two physician progress reports by [REDACTED] on 03/06/2013 and 06/13/2013. The patient was status post left shoulder arthroscopic subacromial decompression and open margin conversion repair of a retracted rotator cuff with biceps tendon graft in 2012. The patient presented to [REDACTED] on 06/13/2013 with complaints of ongoing left shoulder symptomatology. The patient reported no significant improvement following the initial shoulder surgery over one year ago. Physical examination revealed mild tenderness, decreased range of motion, and weakness. It was determined at that time that the patient had reached maximum medical improvement. Treatment recommendations were not provided.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Physiotherapy, three (3) times a week for eight (8) weeks: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation American College of Occupational and Environmental Medicine (ACOEM), second edition Occupational Medicine Practice Guidelines, Reed Group/The Medical Disability Advisor, and the Official Disability Guidelines/Integrated Treatment Guidelines (ODG Treatment in Worke

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

**Decision rationale:** The Chronic Pain Guidelines indicate 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. The guidelines allow for a fading of treatment frequency plus active self-directed home physical medicine. As per the documentation submitted, the patient is status post arthroscopic decompression with rotator cuff repair and biceps tendon graft in 2012. The patient has completed an extensive amount of postoperative physical therapy. Documentation of the previous course of physical therapy, with total treatment duration and treatment efficacy was not provided for review. The medical necessity for ongoing physical therapy has not been established. Additionally, the request for twenty-four (24) sessions of physical therapy exceeds guideline recommendations. Based on the clinical information received, the request is non-certified.