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| <b>Case Number:</b>   | CM13-0048256 |                              |            |
| <b>Date Assigned:</b> | 12/27/2013   | <b>Date of Injury:</b>       | 06/04/2010 |
| <b>Decision Date:</b> | 03/12/2014   | <b>UR Denial Date:</b>       | 10/18/2013 |
| <b>Priority:</b>      | Standard     | <b>Application Received:</b> | 11/05/2013 |

### 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 Orthopedic Surgery 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 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 59-year-old female who reported an injury on 06/04/2010. The patient was diagnosed as status post right shoulder surgery. The patient was recently evaluated on 11/14/2013. The patient reported continuing left shoulder pain with activity limitations and night pain. Physical examination revealed intact sensation, painful range of motion and tenderness to palpation. Treatment recommendations included physical therapy twice per week for six (6) weeks.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Request for twelve (12) physical therapy sessions:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Postsurgical Treatment Guidelines Page(s): 26.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Physical medicine Page(s): 98-99. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder Chapter, Physical Therapy.

**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 and range of motion and can alleviate discomfort. The Guidelines

allow for a fading of treatment frequency plus active, self-directed home physical medicine. The Official Disability Guidelines state that postsurgical treatment for rotator cuff syndrome and impingement syndrome includes twenty-four (24) sessions over fourteen (14) weeks. As per the documentation submitted, the patient is status post a left shoulder subacromial decompression with right shoulder rotator cuff repair. The patient has completed an extensive amount of physical therapy to date. The patient's latest physical therapy evaluation note was submitted on 10/29/2013, following the patient's completion in 62 sessions of physical therapy. Documentation of a significant functional improvement was not provided. Despite ongoing therapy, the patient continued to report limited range of motion, tenderness to palpation and persistent shoulder pain. The patient also reported difficulty with activities of daily living and has not been able to return to work. An additional twelve (12) sessions of physical therapy would exceed the guideline recommendations for a total duration of treatment. Based on the clinical information received, the request is non-certified.