

<b>Case Number:</b>	CM13-0048419		
<b>Date Assigned:</b>	06/09/2014	<b>Date of Injury:</b>	12/07/2010
<b>Decision Date:</b>	07/14/2014	<b>UR Denial Date:</b>	10/03/2013
<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 an expert reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The expert reviewer is Board Certified in Preventative Medicine, has a subspecialty in Occupational 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 injured worker is a 36 year old female whose date of injury is 12/07/2010. The mechanism of injury is described as cumulative trauma. She is status post C6-7 discectomy, decompression and artificial disc placement on 05/31/12. The injured worker is status post left shoulder arthroscopic debridement, open bursectomy, open subacromial and acromioplasty and open repair of the rotator cuff on 01/30/13. Electrodiagnostic study dated 05/29/13 is reported to be a normal study. MR arthrogram of the left shoulder dated 08/30/13 revealed post-surgical changes, and mild tendinopathy of the supraspinatus tendon. Supplemental report dated 09/12/13 indicates that on physical examination the injured worker shows obvious decreased global range of motion because of a frozen shoulder.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**ADDITIONAL PHYSICAL THERAPY 2X/WEEK FOR 4 WEEKS:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Manual therapy and manipulation Page(s): 58-60.

**Decision rationale:** Based on the clinical information provided, the request for additional physical therapy 2 x week for 4 weeks is not recommended as medically necessary. There is no comprehensive assessment of recent treatment completed to date or the injured worker's response thereto submitted for review. There is no current, detailed physical examination submitted for review and no specific, time-limited treatment goals are provided. CA MTUS guidelines would support 1-2 visits every 4-6 months for recurrence/flare-up and note that elective/maintenance care is not medically necessary. The injured worker's compliance with an ongoing active home exercise program is not documented. The request is not medically necessary and appropriate.