

<b>Case Number:</b>	CM13-0058622		
<b>Date Assigned:</b>	12/30/2013	<b>Date of Injury:</b>	12/28/2010
<b>Decision Date:</b>	05/07/2014	<b>UR Denial Date:</b>	11/04/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	11/27/2013

### 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 66-year-old male who reported an injury on 12/28/2010. The mechanism of injury was not provided. Documentation of 10/02/2013 revealed the injured worker was status post right shoulder replacement on 08/26/2013. It was indicated the injured worker was continuing physical therapy for the right wrist. The injured worker's shoulder examination revealed flexion 0 to 100 degrees, abduction 0 to 90 degrees, external rotation 0 to 40 degrees, internal rotation 0 to 50 degrees, adduction and extension 0 to 30 degrees. The diagnoses included right shoulder degenerative joint disease, severe malunited proximal humerus fracture. The treatment plan included, continue with a home exercise program and stretching routine. The request was made for 12 visits of physical therapy for the neck, back and right shoulder for strengthening and conditioning. The injured worker was noted to have undergone 20 physical therapy visits postoperatively.

### IMR ISSUES, DECISIONS AND RATIONALES

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

#### **PHYSICAL THERAPY FOR THE RIGHT SHOULDER, TWO (2) TIMES PER WEEK FOR SIX (6) WEEKS: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Shoulder Complaints, Postsurgical Treatment Guidelines, Shoulder.

**MAXIMUS guideline:** Decision based on MTUS Postsurgical Treatment Guidelines, Arthritis (Osteoarthritis; Rheumatoid arthritis; Arthropathy, unspecified), Page : 27.

**Decision rationale:** California MTUS Postsurgical Treatment Guidelines indicate the appropriate postsurgical treatment for an arthroplasty is 24 visits. The clinical documentation submitted for review indicated the injured worker had participated in 20 sessions of postoperative physical therapy. There was a lack of documentation indicating the objective functional benefit received from the physical therapy and remaining functional deficits. The request for 12 additional sessions of physical therapy would exceed guideline recommendations and there was a lack of documentation of exceptional factors to warrant nonadherence to guideline recommendations. Given the above, the request for physical therapy for the right shoulder 2 times a week for 6 weeks is not medically necessary.