

<b>Case Number:</b>	CM13-0062403		
<b>Date Assigned:</b>	12/30/2013	<b>Date of Injury:</b>	12/28/2010
<b>Decision Date:</b>	04/11/2014	<b>UR Denial Date:</b>	11/22/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	12/06/2013

### 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 OMR and is licensed to practice in Illinois. 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 66 year old male who reported an injury on 12/28/2010. The mechanism of injury was not provided. The note dated 11/14/2013 indicated the patient was status post right shoulder replacement on 08/26/2013. It is noted the patient reported he had completed 24 sessions of physical therapy and was slowly doing a home exercise program. It is noted the patient sees another physician for low back and right lower extremity symptoms. Upon examination of the right shoulder flexion was 0 to 120 degrees, abduction 0 to 110 degrees, external rotation 0 to 50 degrees, internal rotation 0 to 60 degrees, adduction and extension were 0 to 35 degrees. Sensation was intact in the C5 distribution to light touch. The motor exam was deferred due to recent surgery. The diagnoses provided were chronic malunion of humeral neck fracture, severe osteoarthritis of the glenohumeral joint, probable proximal bicipital tendon tear, cervical radiculopathy, lumbar radiculopathy, severe right neural foraminal narrowing at L3-4, multilevel disc herniations of the cervical spine with stenosis, right shoulder degenerative disc disease (severe malunited proximal humerus fracture), and status post right shoulder replacement on 08/26/2013. Under the treatment plan it was noted the physician was requesting 12 visits of physical therapy for the neck, back, and right shoulder for strengthening and conditioning.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**97119-97140, PHYSICAL THERAPY 2 TIMES WEEK FOR 6 WEEKS TO NECK/BACK/RIGHT SHOULDER, 97001,97750,97110,97112: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Page(s): 98-99, Postsurgical Treatment Guidelines Page(s): 27.

**Decision rationale:** The request for (97119 - 97140) physical therapy 2 times a week for 6 weeks to neck, back, right shoulder (97001, 97750, 97110, and 97112) is non-certified. The California MTUS states that postsurgical treatment arthroplasty for the shoulder; it is recommended the patient receive 24 visits over 10 weeks. Furthermore, it is recommended that postsurgical physical medicine treatment is up to 6 months. In addition, the California MTUS states, 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. Furthermore, the California MTUS states that for neuralgia, neuritis, and radiculitis, it is recommended the patient receive 8 to 10 visits of physical therapy over 4 weeks. The medical records submitted for review indicated the patient had completed 24 sessions of physical therapy postoperatively which equals the recommended number of sessions for a right shoulder replacement. It was noted the patient was participating in a home exercise program. Furthermore, the date of surgery was 08/26/2013 which indicated the patient is further than 6 months out from the date of surgery. Furthermore, the records submitted for review failed to include documentation of objective functional deficits of the neck and back to support physical therapy. In addition, the request for physical therapy 2 times a week for 6 weeks exceeds the recommended duration and total number of visits of 8 to 10 visits over 4 weeks. Furthermore, the records provided for review failed to include documentation of previous physical therapy that has been completed and objective functional gains the patient received to support additional physical therapy. As such, the request for (97119-97140), physical therapy 2 times a week for 6 weeks to neck, back, right shoulder (97001, 97750, 97110, and 97112) is not supported. Therefore, the request is non-certified.