

<b>Case Number:</b>	CM14-0109085		
<b>Date Assigned:</b>	09/05/2014	<b>Date of Injury:</b>	07/30/2013
<b>Decision Date:</b>	10/27/2014	<b>UR Denial Date:</b>	06/23/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	07/14/2014

### 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 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 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:

This 33 year-old patient sustained an injury on 7/30/13 while employed by [REDACTED]. Request(s) under consideration include Physical Therapy 2 times a week for 6 weeks to the left shoulder. Diagnoses include left shoulder strain s/p left shoulder arthroscopy on 11/8/13. Therapy report of 12/18/13 noted patient with 23 total cumulative visits with 2 missed appointments. It was noted was off work due to medical restrictions. Exam showed left shoulder range of flex/abd/IR/ER of 133/ 136/ T11/ T2 degrees/levels. Report of 1/17/14 noted patient completed 22 post-op visits with exam findings of flex/abd/IR/ER of 133/ 145/ T11/ T2. Reports of 6/7/14 and 6/14/14 from the provider noted the patient with diagnoses of left shoulder pain and cervical disc disease. The medications were helping the pain. Exam showed diffuse tenderness; decreased DTRs, diffuse decreased sensation with painful shoulder range. Treatment was for continued physical therapy. The request(s) for Physical Therapy 2 times a week for 6 weeks to the left shoulder was non-certified on 6/23/14 citing guidelines criteria and lack of medical necessity.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Physical Therapy 2 times a week for 6 weeks to the left shoulder:** 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 Physical Therapy Page(s): 98-99.

**Decision rationale:** The post-surgical guidelines for shoulder arthroscopy with sub acromial decompression and acromioplasty with debridement has passed beyond the post-operative rehab period for surgery of 11/18/13 and chronic therapy guidelines apply. The patient has received 36 post-operative physical therapy sessions, beyond guidelines recommendations. Physical therapy is considered medically necessary when the services require the judgment, knowledge, and skills of a qualified physical therapist due to the complexity and sophistication of the therapy and the physical condition of the patient. However, there is no clear measurable evidence of progress with the physical therapy treatment already rendered including milestones of increased ROM, strength, and functional capacity. Review of submitted physician reports show no evidence of functional benefit, unchanged chronic symptom complaints, clinical findings, and work status. There is no evidence documenting functional baseline with clear goals to be reached and the patient striving to reach those goals. The Chronic Pain Guidelines allow for 9-10 visits of physical therapy with fading of treatment to an independent self-directed home program. It appears the employee has received significant therapy sessions without demonstrated evidence of functional improvement to allow for additional therapy treatments. There is no report of acute flare-up, new injuries, or change in symptom or clinical findings to support for formal physical therapy in a patient that has been instructed on a home exercise program for this chronic injury. Submitted reports have not adequately demonstrated the indication to support further physical therapy when prior treatment rendered has not resulted in any functional benefit. The Physical Therapy 2 times a week for 6 weeks to the left shoulder is not medically necessary and appropriate.