

<b>Case Number:</b>	CM14-0152346		
<b>Date Assigned:</b>	09/24/2014	<b>Date of Injury:</b>	04/08/2012
<b>Decision Date:</b>	10/24/2014	<b>UR Denial Date:</b>	09/09/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	09/18/2014

### 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 Louisiana. 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 patient is a 64-year-old woman who was injured on 04/08/2012. The mechanism of injury is not known. Medication history included a cortisone injection. She has been treated conservatively with physical therapy. The number of sessions have not been determined. Progress report dated 07/31/2014, indicated the patient presented regarding her right shoulder. She was last seen on 12/09/2013 and she was given a cortisone injection in the acromioclavicular joint and the subacromial space which provided marked pain relief. She still complains of decreased range of motion and increased weakness. She still has pain on extremes of motion. During examination, her shoulders are symmetrical without atrophy. The right shoulder has a well-healed surgical scar and a range of motion of 140/70/60 with pain and guarding. Biceps is symmetrical. There is no tenderness at the acromioclavicular joints although the MP joint sign is positive. There is no rotator cuff weakness. She has pain with objective strength testing. Motor and sensory exams are normal. The patient was diagnosed with status post right acromioplasty and rotator cuff repair and adhesive capsulitis. The patient was recommended for physical therapy. Prior utilization review is dated 09/09/2014 and indicated a request for physical therapy, quantity of 12 is modified to certify physical therapy, quantity 2.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Physical therapy, 12 visits:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine; Functional Improvement measures Page(s): 47, 98.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines physical medicine Page(s): 98-99.

**Decision rationale:** Based on the Chronic Pain Medical Treatment Guidelines, Physical Therapy is recommended for both a passive portion for acute short-term relief and active methods to maintain improvement levels. Guidelines require documentation of objective improvements with previous treatment, functional deficits, functional goals, and a statement identifying why an independent home exercise plan program would be insufficient. In this case, there is a lack of supporting documentation of progression or functional improvement from prior physical therapy provided to indicate the necessity of the request, therefore it is not medically necessary at this time.