

<b>Case Number:</b>	CM14-0184799		
<b>Date Assigned:</b>	11/12/2014	<b>Date of Injury:</b>	11/24/2012
<b>Decision Date:</b>	12/19/2014	<b>UR Denial Date:</b>	10/23/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	11/06/2014

### 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 Orthopedic Surgeon, has a subspecialty in Fellowship Trained in Adult Reconstruction Surgery and is licensed to practice in Pennsylvania. 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 46-year-old female who reported an injury on 11/24/2012. The mechanism of injury was noted as continuous trauma. Her diagnosis was noted as right rotator cuff tear repair. Past treatments included medications, physical therapy, hot packs, and work modifications. On 10/13/2014, the injured worker complained of pain and a pulsing sensation to the right shoulder at the surgical site. Physical examination of the shoulder revealed 130 degrees of forward flexion and 60 degrees of extension. Her current medications were not listed. The treatment plan included supervised exercise, strengthening program, and extension of physical therapy for 12 visits. A request was received for physical therapy 3x4. The rationale for the request was not provided. The Request for Authorization form was not submitted.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Physical Therapy 3 times a week for 4 weeks through [REDACTED]: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Postsurgical Treatment Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Shoulder Chapter.

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

**Decision rationale:** California MTUS Guidelines recommend up to 10 visits of physical therapy for myalgia and myositis. The clinical notes indicate that the injured worker complained of continuing pain to the right shoulder after surgery. However, there is no documented evidence of previous physical therapy after surgery or functional improvement with therapy. In the absence of documentation indicating evidence of previous physical therapy with functional improvement and as the request would exceed the recommendations according to guidelines, the request is not supported. In addition, the request does not specify what area of the body physical therapy would be provided for. Therefore, the request for Physical Therapy 3 times a week for 4 weeks through [REDACTED] are not medically necessary.