

<b>Case Number:</b>	CM14-0032274		
<b>Date Assigned:</b>	06/20/2014	<b>Date of Injury:</b>	09/29/2012
<b>Decision Date:</b>	07/18/2014	<b>UR Denial Date:</b>	02/27/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	03/13/2014

### 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 61 year-old patient sustained an injury on 9/29/12. The report of 1/20/14 from the provider noted the patient to be with bilateral shoulder pain, with right side most severe. Exam showed trapezius tenderness, decreased neck range with pain, decreased thoracic range, normal upper extremity sensation, normal reflexes and pulses, bilateral rotator cuff weakness, tenderness at subacromial and subdeltoid bursa, positive impingement signs and Hawkins' tests, decreased range of motion, normal knee range, straight leg raise at 50 degrees, and lumbar paravertebral tenderness with normal bilateral lower extremity motor strength and sensation. Diagnoses include right shoulder rotator cuff tear/ impingement syndrome, left shoulder partial thickness rotator cuff tear/ impingement syndrome, cervical spine myoligamentous sprain/strain/discopathy, and lumbar spine myoligamentous sprain/strain/discopathy. Review indicated the patient has been certified for right shoulder arthroscopy.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**One three post-op physical therapy sessions between 1/20/2014 and 4/26/2014: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** Decision based on MTUS Postsurgical Treatment Guidelines.

**Decision rationale:** 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 treatment already rendered, including milestones of increased range of motion, strength, and functional capacity. Review of submitted physician reports show no evidence of functional benefit, unchanged chronic symptom complaints, nonspecific 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 Medical Treatment Guidelines allow for physical therapy with fading of outpatient treatment and the transition to an independent self-directed home program. The employee has received physical therapy visits for the arthroscopic repair; however, there is not an identified number of visits or documented evidence of functional improvement to allow for additional therapy treatments. As such, the request is not medically necessary.