

<b>Case Number:</b>	CM14-0037577		
<b>Date Assigned:</b>	06/25/2014	<b>Date of Injury:</b>	08/14/2010
<b>Decision Date:</b>	07/28/2014	<b>UR Denial Date:</b>	03/11/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	03/28/2014

### 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 34-year-old patient sustained an injury on August 14, 2010 from restraining an agitated patient while employed by [REDACTED]. Request(s) under consideration include Physical therapy right shoulder two times a week for six weeks. The patient is s/p right shoulder arthroscopy on November 1, 2013 with at least 22 post-op PT (physical therapy) visits to date for surgery over nine months past. Current diagnoses include shoulder and upper arm sprain. Report of March 3, 2014 from the provider noted the patient with ongoing complaints of pain, stiffness, weakness, and numbness in right shoulder. Exam of right shoulder showed tenderness on palpation, limited range of motion limited by pain; muscle spasm; motor strength of 4/5. Current medications include Oxycodone and Zolpidem. Request(s) for Physical therapy right shoulder two (2) times a week for six (6) weeks was non-certified on March 11, 2014 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 right shoulder two (2) times a week for six (6) weeks: Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Post-surgical Physical Therapy Section.

**Decision rationale:** This 34-year-old sustained an injury on August 14, 2010 from restraining an agitated patient while employed by [REDACTED]. Request(s) under consideration include Physical therapy right shoulder two times a week for six weeks. The patient is s/p right shoulder arthroscopy on November 1, 2013 with at least 22 post-operative physical therapy visits to date for surgery over nine months past. Current diagnoses include shoulder and upper arm sprain. Report of March 3, 2014 from the provider noted the patient with ongoing complaints of pain, stiffness, weakness, and numbness in right shoulder. Exam of right shoulder showed tenderness on palpation, limited range of motion limited by pain; muscle spasm; motor strength of 4/5. Current medications include Oxycodone and Zolpidem. The Chronic Pain Guidelines allow for physical therapy with fading of treatment to an independent self-directed home program. The employee has received at least 22 authorized PT visits for the arthroscopic repair over 9 months ago without demonstrated evidence of functional improvement to allow for additional therapy treatments. Chronic Pain Guidelines, post-operative therapy allow for 24 visits over fourteen weeks for shoulder arthroscopy with postsurgical physical medicine treatment period of 6 months. Submitted reports have not adequately demonstrated the indication to support further physical therapy beyond the guidelines criteria of 24 with request for an additional twelve visits. 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 PT 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. There is no report of acute flare-up, new injuries, or change in symptom or clinical findings to support for formal PT 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 request for physical therapy for the right shoulder, twice weekly for six weeks, is not medically necessary or appropriate.