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| <b>Case Number:</b>   | CM14-0065575 |                              |            |
| <b>Date Assigned:</b> | 07/11/2014   | <b>Date of Injury:</b>       | 05/31/2013 |
| <b>Decision Date:</b> | 12/24/2014   | <b>UR Denial Date:</b>       | 04/17/2014 |
| <b>Priority:</b>      | Standard     | <b>Application Received:</b> | 05/08/2014 |

### 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 Orthopaedic Surgery 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 59-year-old female laborer sustained an industrial injury on 5/31/13. The mechanism of injury was not documented. The patient sustained a fractured right elbow and right ankle. She underwent open reduction and internal fixation of the right elbow on 6/11/13. Records documented persistent right shoulder pain and weakness. The 10/16/13 right shoulder MRI impression documented a complete tear of the anterior supraspinatus tendon, partial tear or tendinosis of the infraspinatus tend, and near complete tears of the subscapularis tendon with mild medial subluxation of the proximal biceps tendon. There was a possible SLAP tear or degeneration of the superior posterior labrum. There was mild to moderate acromioclavicular joint osteoarthritis. A right shoulder arthroscopy with synovectomy, bursectomy, resection of the subacromial bursa, coracoacromial ligament resection, subacromial decompression, and rotator cuff repair was performed on 1/8/14. Records indicated that the patient had completed 46 physical therapy sessions. The 4/17/14 utilization review denied the request for additional physical therapy as there were no current abnormal clinical findings to support additional treatment.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Physical therapy for the right shoulder, right elbow and right ankle, 2 times a week for 6 weeks, QTY: 12: Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Introduction, Physical medicine Page(s): 9, 98-99, Postsurgical Treatment Guidelines Page(s): 27.

**Decision rationale:** The California MTUS Post-Surgical Treatment Guidelines for complete rupture of the rotator cuff generally support 40 post-operative visits over 16 weeks during the 6-month post-surgical treatment period. If it is determined that additional functional improvement can be accomplished after completion of the general course of therapy, physical medicine treatment may be continued up to the end of the postsurgical physical medicine period. The post-surgical treatment period would have continued through 7/8/14. There was no evidence of a specific functional deficit to be addressed by additional treatment relative to the right shoulder. Relative to right elbow and ankle, the California MTUS guidelines recommend therapies focused on the goal of functional restoration rather than merely the elimination of pain. The physical therapy guidelines state that patients are expected to continue active therapies at home as an extension of treatment and to maintain improvement. There is no current documentation relative to the right elbow and ankle to support the medical necessity of this request. There is no diagnosis or pain assessment in the available records. There is no specific functional deficit or treatment goal to be addressed by additional therapy. There is no compelling reason to support the medical necessity of additional supervised physical therapy over an independent home exercise program. Therefore, this request is not medically necessary.