MAXIMUS Federal Services

| Case Number: | CM15-0108562 | | |
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| Date Assigned: | 06/15/2015 | Date of Injury: | 08/04/2014 |
| Decision Date: | 07/14/2015 | UR Denial Date: | 05/26/2015 |
| Priority: | Standard | Application Received: | 06/05/2015 |

## 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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:
State(s) of Licensure: Maryland
Certification(s)/Specialty: Physical Medicine & Rehabilitation, Neuromuscular Medicine

## 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 48 year old male, who sustained an industrial injury on 8/4/14. He reported pain in the right shoulder after pushing a heavy object. The injured worker was diagnosed as having adhesive capsulitis and joint pain. Treatment to date has included a right rotator cuff repair on 11/26/14, manipulation under anesthesia 2/25/15, physical therapy x 24 sessions and oral pain medications. As of the PR2 dated 4/16/15, the injured worker reports 4/10 pain in his right shoulder. He has completed his physical therapy and is performing home exercises, but still has limited range of motion. The treating physician performed an intra-articular joint injection into the right shoulder. Objective findings include right shoulder range of motion flexion 150 degrees and external rotation at 90 degrees was 60 degrees. The treating physician requested additional post-operative physical therapy 3 x 4, a home exercise chair and a home interferential unit.

## IMR ISSUES, DECISIONS AND RATIONALES

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

**Additional post-op physical therapy 3 x 4:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Physical medicine Page(s): 98-99. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder - Adhesive capsulitis (IC9 726.0).

**Decision rationale:** Additional post-op physical therapy 3 x 4 is not medically necessary per the MTUS and the ODG. The ODG recommends 24 post op visits after manipulation under anesthesia. The documentation indicates that the patient has had 24 PT sessions. The documentation does not indicate findings that would necessitate 12 more supervised PT sessions. The MTUS recommends transitioning to an independent home exercise program. The request for additional post op physical therapy 3 x 4 is not medically necessary.

**Home exercise chair:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Exercise and physical medicine Page(s): 46-47 and 98-99.

**Decision rationale:** A home exercise chair is not medically necessary per the MTUS and the ODG Guidelines. The MTUS states that there is no sufficient evidence to support the recommendation of any particular exercise regimen over any other. The documentation does not reveal extenuating factors that would necessitate a home exercise chair for the patient's recovery and rehabilitation. The MTUS supports an independent home exercise program and there is no documentation that would require a home exercise chair to be medically necessary for this patient.

**Home interferential unit:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Interferential Current Stimulation (ICS)-Page(s): 118-120.

**Decision rationale:** Home interferential unit is not medically necessary per the MTUS Chronic Pain Medical Treatment Guidelines. The guidelines state that in regards to interferential therapy there is no quality evidence of effectiveness except in conjunction with recommended treatments, including return to work, exercise and medications, and limited evidence of improvement on those recommended treatments alone. The MTUS states that one-month trial may be appropriate to permit the physician and physical therapy provider to study the effects and benefits. There should be evidence of increased functional improvement, less reported pain and evidence of medication reduction. The documentation does not indicate outcomes of a one month trial of an interferential unit in results to pain and functional improvement therefore a home interferential unit is not medically necessary.