

<b>Case Number:</b>	CM15-0141460		
<b>Date Assigned:</b>	07/30/2015	<b>Date of Injury:</b>	01/23/2012
<b>Decision Date:</b>	08/27/2015	<b>UR Denial Date:</b>	07/13/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	07/20/2015

### 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: California

Certification(s)/Specialty: Physical Medicine & Rehabilitation

### 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 59 year-old female, who sustained an industrial injury on 01-23-2012. She has reported injury to the right shoulder. The diagnoses have included status post right shoulder arthroscopic decompression with lateral clavicular resection and rotator cuff repair, on 06-19-2014; and anxiety and depression. Treatment to date has included medications, diagnostics, chiropractic therapy, physical therapy, home exercise program, and surgical intervention. Medications have included Tylenol No.3. A progress note from the treating physician, dated 05-26-2015, documented a follow-up visit with the injured worker. The injured worker reported right shoulder pain with increased activity; and she continues to have anxiety and depression. Objective findings included decreased range of motion of the right shoulder. The treatment plan has included the request for physical therapy 3 x 3 for the right shoulder.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Physical Therapy 3 x 3 weeks for the Right Shoulder:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Physical Therapy, pages 98-99.

**Decision rationale:** Time-limited care plan with specific defined goals, assessment of functional benefit with modification of ongoing treatment based upon the patient's progress in meeting those goals and the provider's continued monitoring of successful outcome is stressed by MTUS guidelines. 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. Submitted reports have no acute flare-up or specific physical limitations to support for physical/ occupational therapy. The Chronic Pain Guidelines allow for visits of therapy with fading of treatment to an independent self-directed home program. It is unclear how many PT sessions have been completed; however, the submitted reports have not identified clear specific functional improvement in ADLs, functional status, or decrease in medication and medical utilization nor have there been a change in neurological compromise or red-flag findings demonstrated from the formal physical therapy already rendered to support further treatment. The Physical Therapy 3 x 3 weeks for the Right Shoulder is not medically necessary and appropriate.