

<b>Case Number:</b>	CM15-0035416		
<b>Date Assigned:</b>	03/03/2015	<b>Date of Injury:</b>	03/04/2013
<b>Decision Date:</b>	04/08/2015	<b>UR Denial Date:</b>	02/09/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	02/25/2015

### 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 51 year old male injured worker suffered an industrial injury on 3/4/2013. The diagnoses were pain in the joint, shoulder region, supraspinatus sprain and left shoulder arthroscopy 11/4/2014. The treatments were physical therapy sessions. The treating physical therapist reported pain is 4 to 5/10 to the left shoulder and noted weakness with decreased range of motion. The Utilization Review Determination on 2/9/2015 non-certified Post-Operative additional Physical Therapy one two times a week for eight weeks, total sixteen visits , Left Shoulder, Quantity 16, MTUS, ACOEM, ODG.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Post-Operative Physical Therapy one two times a week for eight weeks, total sixteen visits, Left Shoulder, Quantity 16: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 203. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Physical Therapy for the shoulder.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Post-surgical Therapy for Shoulder Rotator cuff syndrome/Impingement syndrome (ICD9 726.1; 726.12): Postsurgical treatment, arthroscopic: 24 visits over 14 weeks.

**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 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, 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 Guidelines allow for physical therapy with fading of treatment to an independent self-directed home program. The employee has received PT visits for the arthroscopic repair 5 months ago; however without identified number of visits or demonstrated evidence of functional improvement to allow for additional therapy treatments. Post-surgical guidelines allow for up to 24 visits post arthroscopic shoulder repair over a rehab period of 3-4 months. The Post-Operative additional Physical Therapy one two times a week for eight weeks, total sixteen visits, Left Shoulder, Quantity 16 is not medically necessary and appropriate.