

<b>Case Number:</b>	CM15-0058195		
<b>Date Assigned:</b>	04/02/2015	<b>Date of Injury:</b>	07/03/2013
<b>Decision Date:</b>	05/04/2015	<b>UR Denial Date:</b>	03/17/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	03/26/2015

### 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: Massachusetts

Certification(s)/Specialty: Physical Medicine & Rehabilitation, Pain Management

### 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 64 year old female who sustained an industrial injury on July 3, 2013. The injured worker was diagnosed with right rotator cuff tear, left shoulder impingement and cervical strain. The injured worker is status post shoulder surgery (no procedure noted) in June 2014. According to the primary treating physician's progress report on March 9, 2015, the injured worker continues to experience right shoulder pain but improving with physical therapy. Examination of the cervical spine demonstrated spasm with decreased range of motion and diminished sensation to light touch. The right upper extremity was hypertrophic at the acromioclavicular joint with limited range of motion and worsening strength. A positive Neer and Hawkins were noted. Left upper extremity demonstrated limited range of motion, full strength and normal sensation. No pathological deep tendon reflexes were noted. Current medications were not listed. Treatment plan consists of continuing with home exercise program and the request for additional physical therapy.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Additional physical therapy - 18 visits:** Upheld

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

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) (1) Chronic pain, Physical medicine treatment. (2) Preface, Physical Therapy Guidelines.

**Decision rationale:** The claimant is nearly 2 years status post work-related injury and underwent rotator cuff repair surgery in June 2014 followed by post-operative physical therapy. When seen, recommendations included a continued home exercise program and additional physical therapy. In terms of physical therapy, patients are expected to continue active therapies at home. Compliance with a home exercise program would be expected and would not require continued skilled physical therapy oversight. A home exercise program could be performed as often as needed/appropriate rather than during scheduled therapy visits and could include use of TheraBands and a home pulley system for strengthening and range of motion. The claimant has no other identified impairment that would preclude performing such a program. Providing the requested additional skilled physical therapy services would not reflect a fading of treatment frequency and would promote dependence on therapy provided treatments. Therefore the request is not medically necessary.