

<b>Case Number:</b>	CM14-0162744		
<b>Date Assigned:</b>	10/07/2014	<b>Date of Injury:</b>	09/21/2010
<b>Decision Date:</b>	10/30/2014	<b>UR Denial Date:</b>	09/10/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/03/2014

### 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 Physical Medicine and Rehabilitation 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 44-year-old patient sustained an injury on 9/21/10 while employed by [REDACTED]. Request(s) under consideration include Additional physical therapy 6-8 weeks Qty: 1.00. Diagnoses include left shoulder impingement s/p left arthroscopy with SAD with acromioplasty and labral debridement on 4/30/12 and s/p cervical fusion (February 2013) stable per scan of 12/14/13. Conservative care has included medications, therapy, cervical interlaminar epidural steroid injection, and modified activities/rest. Report of 5/12/14 from the patient noted with shoulder pain radiating proximally and in AC joint; neck fusion but with continued focal pain to left shoulder. Exam showed positive impingement and AC joint arthropathy. Physical therapy report of 8/13/14 noted neck very stiff with same unchanged left shoulder pain. Plan recommended continued PT. Report of 7/29/14 from the provider noted patient still with pain and discomfort in shoulder along with cervical region radiculopathy into the upper extremities and arms. The patient was reported to have some crepitus with audible clunk with rotational activity with plan for continued therapy. The patient remained not working. The request(s) for Additional physical therapy 6-8 weeks Qty: 1.00 was non-certified on 9/10/14 citing guidelines criteria and lack of medical necessity.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Additional physical therapy 6-8 weeks Qty: 1.00:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Page(s): 98-99.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Post-surgical Therapy for Shoulder Rotator cuff syndrome/Impingement syndrome (ICD9 726.1; 726.1).

**Decision rationale:** The request(s) for Additional physical therapy 6-8 weeks Qty: 1.00 was non-certified on 9/10/14. The patient remained not working. There is a peer review dated 5/21/14 with certification of left shoulder arthroscopic SAD and acromioplasty with post-op PT 2x4. There is an operative report dated 6/11/14 for left shoulder arthroscopy without complications. Report of 7/8/14 noted patient one month post left shoulder arthroscopic debridement and still on four Norco/day. Exam showed left shoulder with no change in neurological function; DTRs symmetrical with 20 pounds grip strength. Cervical x-rays showed solid cervical C5-7 fusion. The Chronic Pain Guidelines allow for physical therapy with fading of treatment to an independent self-directed home program. 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, 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 unspecified number of authorized PT visits for the arthroscopic repair without demonstrated evidence of functional improvement from submitted reports to allow for additional therapy treatments. The Additional physical therapy 6-8 weeks Qty: 1.00 is not medically necessary and appropriate.