

<b>Case Number:</b>	CM14-0111436		
<b>Date Assigned:</b>	08/01/2014	<b>Date of Injury:</b>	10/31/2011
<b>Decision Date:</b>	02/27/2015	<b>UR Denial Date:</b>	06/19/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	07/16/2014

### 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. 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: Indiana

Certification(s)/Specialty: Preventive Medicine, Occupational 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 patient is a 48 year old female who sustained a work related injury as a waitress to her right shoulder and right hand on October 31, 2011. The injured worker underwent a right rotator cuff repair on May 16, 2012 according to the Utilization Review determination letter. The patient has had physical therapy (unknown number, dates and benefit). No current radiological reports were submitted for review. The patient continues to experience constant shoulder pain with repetitive movement and occasional numbness and tingling in the right arm. According to the orthopedic surgeon's evaluation report on May 16, 2014 the injured worker had crepitus and pain with positive Hawkins and Neer signs and tenderness along the supraspinatus insertion. Examination of the right shoulder demonstrated passive range of motion of forward flexion to 170 degrees, abduction to 160 degrees, external 70 degrees, and internal rotation to 80 degrees. Active range of motion was forward flexion 160 degrees, abduction 150 degrees, external rotation 50 degrees, and internal rotation 60 degrees. Current treatment plan is Motrin as needed and to finish the course of therapy. The orthopedic surgeon's diagnosis was partial re-tear of the rotator cuff supraspinatus tendon. The injured worker is Permanent & Stationary (P&S) and works with modified duties. The physician requested authorization for physical therapy twice a week for 4 weeks, QTY: 8 sessions to increase range of motion, flexibility, strength, and function to the right upper extremity. On June 19, 2014 the Utilization Review denied certification for physical therapy twice a week for 4 weeks, QTY: 8 sessions due to lack of functional improvement from prior therapy. Citation used in the decision process was the Official Disability Guidelines - Treatment & Workman's Compensation (ODG-TWC) Shoulder Chapter-Physical Therapy.

## IMR ISSUES, DECISIONS AND RATIONALES

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

**Physical therapy treatment, 2 times a week for 4 weeks, QTY: 8 sessions:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Treatment in Workers Compensation (TWC), 18th Edition, 2013 Updates: Shoulder Chapter, Rotator Cuff Syndrome/Impingement Syndrome

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Physical therapy Page(s): 98-99. Decision based on Non-MTUS Citation Shoulder Physical Therapy

**Decision rationale:** California MTUS guidelines refer to physical medicine guidelines for physical therapy. ?Allow for fading of treatment frequency (from up to 3 visits per week to 1 or less), plus active self-directed home Physical Medicine. Regarding physical therapy, ODG states ?Patients should be formally assessed after a "six-visit clinical trial" to see if the patient is moving in a positive direction, no direction, or a negative direction (prior to continuing with the physical therapy); & (6) When treatment duration and/or number of visits exceeds the guideline, exceptional factors should be noted. At the conclusion of this trial, additional treatment would be assessed based upon documented objective, functional improvement, and appropriate goals for the additional treatment. The employee had previous sessions of physical therapy, but there is no evidence of "functional improvement, and appropriate goals for the additional treatment." Therefore, the request for Physical therapy treatment, 2 times a week for 4 weeks, QTY: 8 sessions is not medically necessary.