

<b>Case Number:</b>	CM15-0116624		
<b>Date Assigned:</b>	06/24/2015	<b>Date of Injury:</b>	06/15/2013
<b>Decision Date:</b>	07/23/2015	<b>UR Denial Date:</b>	05/26/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	06/16/2015

### 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 42 year old male, who sustained an industrial injury on 6/15/2013. Diagnoses include mild residual lumbar pain with improved radiculopathy, exacerbated cervical pain and history of bilateral shoulder surgeries with residual pain. Treatment to date has included a left rotator cuff repair on 1/30/2015. He has also undergone physical therapy, and injections. Per the Secondary Physician Pain Management Report dated 5/20/2015, the injured worker reported pain level in the low back as 4/10 and almost very rarely associated with lower extremity symptoms. He has neck pain rated as 8/10 and reports difficulty with any activity above shoulder level because of the combination of neck and shoulder pain. Physical examination revealed no signs of sedation. Straight leg raise was negative. There was tenderness and spasm noted over the lumbar spine area which was described as mild. There was also tenderness noted over the cervical paraspinous area with normal range of motion. The plan of care included physical therapy and authorization was requested for physiotherapy (3x4) for the right shoulder and physiotherapy (3x6) for the left shoulder.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Physiotherapy 3 x a week for 4 weeks for the right shoulder: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Postsurgical Treatment Guidelines.

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

**Decision rationale:** The patient is s/p right shoulder SAD in April 2014, over 15 months ago without reported events. 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 functional 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 visits of physical therapy with fading of treatment to an independent self-directed home program. It appears the employee has received significant therapy sessions without demonstrated evidence of functional improvement to allow for additional therapy treatments. There is no report of acute flare-up, new injuries, or change in symptom or clinical findings to support for formal PT in a patient that has been instructed on a home exercise program for this chronic injury. Submitted reports have not adequately demonstrated the indication to support further physical therapy when prior treatment rendered has not resulted in any functional benefit. The Physiotherapy 3 x a week for 4 weeks for the right shoulder is not medically necessary or appropriate.

**Physiotherapy 3 x a week for 6 weeks for the left shoulder:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Postsurgical Treatment Guidelines.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Post-surgical Therapy for Shoulder; Sprained shoulder; rotator cuff (ICD9 840; 840.4); Labral lesion: Postsurgical treatment (RC repair/acromioplasty): 24 visits over 14 weeks; Postsurgical physical medicine treatment period: 6 months.

**Decision rationale:** The patient is s/p left shoulder arthroscopic rotator cuff repair on 1/30/15 with post-operative therapy. It is now over 5-1/2 months from surgical procedure. The Chronic Pain Guidelines allow for physical therapy with fading of treatment to an independent self-directed home program. It is unclear how many PT visits have been completed; however submitted reports are without specific demonstrated evidence of functional improvement to allow for additional therapy treatments. Post-surgical guidelines allow for up to 24 visits post arthroscopic rotator cuff repair over 14 weeks over a 6 month rehab period. 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

Physiotherapy 3 x a week for 6 weeks for the left shoulder is not medically necessary or appropriate.