

<b>Case Number:</b>	CM15-0119767		
<b>Date Assigned:</b>	06/30/2015	<b>Date of Injury:</b>	01/28/2014
<b>Decision Date:</b>	07/29/2015	<b>UR Denial Date:</b>	06/10/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	06/22/2015

### 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 40 year old female, who sustained an industrial injury on 1/28/14. The injured worker was diagnosed as having stage III impingement status post arthroscopic subacromial decompression with superior labrum anterior posterior repair performed on 10/17/14. Treatment to date has included physical therapy, a home exercise program, and medication including Flexeril and Motrin. Physical examination findings on 5/27/15 revealed some compensatory posturing and mildly positive impingement. Currently, the injured worker complains of right shoulder pain. The treating physician requested authorization for additional physical therapy for the right shoulder 2x4 and a MRA of the right shoulder.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Additional Physical Therapy, Right Shoulder, 2 times wkly for 4 wks, 8 sessions:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine, Postsurgical Treatment Guidelines.

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

**Decision rationale:** It has been over 9 months since the patient's shoulder arthroscopy on 10/17/14 whereby, the chronic guidelines are applicable. 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 Additional Physical Therapy, Right Shoulder, 2 times w/ky for 4 wks, 8 sessions is not medically necessary and appropriate.

**MR (magnetic resonance) Arthrogram, Right Shoulder:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 207, 214, table 9-6. Decision based on Non-MTUS Citation Official Disability Guidelines: Shoulder - MR (magnetic resonance) Arthrogram.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): Chapter 9, Shoulder Complaints, Special Studies and Diagnostic Considerations, page 209.

**Decision rationale:** Per MTUS Treatment Guidelines, criteria for ordering imaging studies are, red flag, physiologic evidence of tissue insult or neurologic dysfunction, failure to progress in a strengthening program intended to avoid surgery, and for clarification of the anatomy prior to an invasive procedure. Clinical report does not demonstrate such criteria and without clear specific evidence to support the diagnostic studies, failed conservative trial, demonstrated limited ADL function, acute flare-up, new injury, progressive clinical deterioration or specific surgical lesion, the medical necessity for shoulder MRA has not been established. The MR (magnetic resonance) Arthrogram, Right Shoulder is not medically necessary and appropriate.