

<b>Case Number:</b>	CM13-0052417		
<b>Date Assigned:</b>	12/27/2013	<b>Date of Injury:</b>	07/30/2010
<b>Decision Date:</b>	04/24/2014	<b>UR Denial Date:</b>	10/03/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/30/2013

### 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 Orthopedic Surgery 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:

Patient is a 41 year old male with an industrial injury on 7/30/10. Patient has a chief complaint of neck pain and bilateral shoulder pain. Exam notes from 11/16/12 demonstrate right shoulder flexion from 0-160 degrees, abduction 0-140 degrees, external and internal rotation 0-80 degrees. Tender over acromioclavicular joint with direct palpation. The exam documents negative drop-arm test, positive subacromial bursitis, positive impingement, negative apprehension, positive O'Brien's. Sensation was intact to C5 distribution to light touch. Exam notes from 8/2/13 demonstrate pain is rated 7-8/10. Exam revealed bilateral deltoid, bicep, internal rotation and external rotation were 5-/5 on the right. Exam notes from 11/1/13 demonstrate patient has failed conservative treatments including anti-inflammatories, analgesics, physical therapy, cortisone injection, and activity modifications. The patient declares the pain is "unbearable" and affects daily living. Peer review report demonstrates non-certification on 10/3/13. Request is for post-op physical therapy 2 times a week for 6 weeks for the right shoulder.

### IMR ISSUES, DECISIONS AND RATIONALES

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

#### **POST-OP PT 2 TIMES A WEEK TIMES 6 WEEKS FOR THE RIGHT SHOULDER:**

Upheld

**Claims Administrator guideline:** Decision based on MTUS Postsurgical Treatment Guidelines  
Page(s): 27.

**MAXIMUS guideline:** Decision based on MTUS Postsurgical Treatment Guidelines Page(s): 27.

**Decision rationale:** As the surgical procedure is denied, the determination is for non-certification for postoperative physical therapy for the shoulder.