

<b>Case Number:</b>	CM13-0062022		
<b>Date Assigned:</b>	04/23/2014	<b>Date of Injury:</b>	06/28/2000
<b>Decision Date:</b>	05/26/2014	<b>UR Denial Date:</b>	11/26/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	12/04/2013

### 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 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 is a 51 year old female who sustained a repetitive use work injury on 06/28/2000. She reported bilateral shoulder and wrist pain. The treatment history includes physical therapy, medications, injections, work restrictions, carpal tunnel release on 09/12/2011 and right shoulder arthroscopic open rotator cuff repair with distal clavicle excision on 09/12/2011. She also completed at least 24 visits of postop physical therapy. MRI arthrogram of the left shoulder dated 11/11/2013 showed tear of the distal anterior portion of the left supraspinatus tendon. MRI arthrogram of the right shoulder dated 11/11/2013 showed status post right rotator cuff repair and attenuation of the supraspinatus tendon and bursal sided tear of the right supraspinatus tendon as well as development of a tear of the posterosuperior and superior portions of the labrum. A progress note dated 10/17/2013 indicates well-healed surgical incision on right shoulder, positive impingement test bilaterally, AC joint tenderness bilaterally, yet worse on right than left. Bilateral shoulder flexion of 120 degrees with 40 degrees external rotation. Diagnosis was bilateral shoulder impingement, symptomatic AC joint arthritis and possible RTC tears bilaterally. A progress report dated 10/30/2013 indicates subjective complaints of left shoulder pain with popping with lifting objects. Objective assessment notes examination unchanged.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**PHYSICAL THERAPY TREATMENT TO THE LEFT AND RIGHT SHOULDERS FOR 12 SESSIONS 2 TIMES A WEEK FOR 6 WEEKS:** Upheld

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

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

**Decision rationale:** As per California MTUS Chronic Pain Medical Treatment Guidelines, physical medicine is based on the philosophy that therapeutic exercise and/or activity are beneficial for restoring flexibility, strength, endurance, function, range of motion, and can alleviate discomfort. In this case, this patient has had right shoulder arthroscopic surgery in September 2011 and has had an extensive course of physical therapy program. There is no documentation that the prior trial of physical therapy resulted in objective functional improvement. There is documentation that the patient continues to have bilateral shoulder pain. It is unclear why an additional course of physical therapy is needed when the prior treatment did not have good outcome. Also, the request is for 12 sessions of physical therapy; however, guidelines recommend 9-10 sessions for myalgia/myositis and 8-10 sessions for neuralgia/neuritis/radiculitis with fading of treatment frequency (from up to 3 visits per week to 1 or less), plus active self-directed home physical medicine. The request exceeds the guidelines recommendation and therefore, it is considered not medically necessary.