

<b>Case Number:</b>	CM13-0070154		
<b>Date Assigned:</b>	01/03/2014	<b>Date of Injury:</b>	04/12/2012
<b>Decision Date:</b>	07/11/2014	<b>UR Denial Date:</b>	12/06/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	12/24/2013

### 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, has a subspecialty in Interventional Spine 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:

The patient is a 71-year-old female with date of injury of 04/12/12. The treating physician report dated 11/12/13 indicates that the patient presents with constant neck pain, rated 4-5/10, with radiation to the left upper extremity with associated headaches. The current diagnoses are: 1. Left upper extremity radiculopathy; 2. Cervical radiculopathy with multilevel disc herniation, stenosis and spondylosis; 3. Aggravation of hypertension; 4. Anxiety secondary to orthopedic injury; and 5. Status post left shoulder reverse total shoulder replacement on 04/19/13. The utilization review report dated 12/6/13, denied the request for physical therapy three (3) times a week for six (6) weeks for the left shoulder and modified the request to three (3) times a week for four (4) weeks for the left shoulder based on the rationale that the patient had already completed thirty-six (36) sessions of post surgical physical therapy.

### IMR ISSUES, DECISIONS AND RATIONALES

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

#### **PHYSICAL THERAPY FOR THE LEFT SHOULDER THREE (3) TIMES A WEEK FOR SIX (6) WEEKS: 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).

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Page(s): 98, 99, Postsurgical Treatment Guidelines Page(s): 26, 27.

**Decision rationale:** The patient presents with seven (7) months post left shoulder reverse total shoulder replacement. The current request is for physical therapy left shoulder three (3) times a week for six (6) weeks. The MTUS Postsurgical Guidelines indicate that the time frame for treatment is stated as, "Postsurgical treatment, arthroplasty, shoulder: 24 visits over 10 weeks \*Postsurgical physical medicine treatment period: 6 months." The Chronic Pain Guidelines recommend eight to ten (8-10) sessions for myalgia-type symptoms. The patient has previously received twenty-four (24) post surgical physical therapy (PT) sessions, and was authorized for an additional twelve (12) sessions on 11/11/13. The twelve (12) sessions that were authorized on 11/11/13 already exceed the ten (10) recommended sessions according to the guidelines. The request is not supported at this time.