

<b>Case Number:</b>	CM14-0006757		
<b>Date Assigned:</b>	02/07/2014	<b>Date of Injury:</b>	05/24/2012
<b>Decision Date:</b>	06/09/2014	<b>UR Denial Date:</b>	12/27/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	01/15/2014

### 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 Texas. 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 injured worker is a 36 year old male whose date of injury is 05/24/2012. On this date a pressurized tote lid blew off and a bolt struck the patient; the patient fell off a ladder and landed on his back. A Magnetic Resonance Image (MRI) of the left shoulder dated 06/19/13 revealed mild degenerative changes of the acromioclavicular joint with a small amount of fluid within the subacromial bursa. A progress note dated 10/28/13 indicates the injured has been unresponsive to conservative treatment including physical therapy, cortisone injection, medication management, chiropractic care and acupuncture. The injured continues to complain of left shoulder pain and weakness. A note dated 12/23/13 indicates the injured has been recommended for left shoulder arthroscopy, subacromial decompression and distal clavicle excision. The request is for post operative physical therapy to the left shoulder.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**POST OP PHYSICAL THERAPY SHOULDER - LEFT:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Postsurgical Treatment Guidelines Rotator Cuff Syndrome/Impingement Syndrome, page 27.

**Decision rationale:** Based on the clinical information provided, the request for post op physical therapy to the left shoulder is not recommended as medically necessary. It appears that the patient has been authorized for left shoulder arthroscopy as well as 12 postoperative physical therapy visits to date. The submitted records fail to provide the operative report. Additionally, there are no postoperative physical therapy progress notes submitted for review documenting the patient's objective functional response to treatment. There is no current, detailed physical examination submitted for review and no specific, time-limited treatment goals are provided. The current request is nonspecific and does not indicate the frequency and duration of the requested physical therapy.