

<b>Case Number:</b>	CM14-0019209		
<b>Date Assigned:</b>	04/21/2014	<b>Date of Injury:</b>	07/15/2009
<b>Decision Date:</b>	07/02/2014	<b>UR Denial Date:</b>	01/31/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	02/14/2014

### 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 Orthopaedic 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:

This 29-year-old female concierge sustained an industrial injury on 7/15/09 when a heavy steel safe fell from an overhead shelf and struck her on the left side of the head, face, and left shoulder area. The 7/18/12 left shoulder MRI impression documented type II acromion, peaking of the outer portion of the acromion with impingement upon the supraspinatus tendon insertion to the humeral head with tendinosis changes. There was a partial intrasubstance tear at the area of the insertion, measuring 0.8 cm, but no full thickness tear, medial retraction, or atrophy. Evaluation with MR arthrogram was recommended. The 1/6/14 orthopedic progress report cited subjective complaints of grade 8-9/10 left shoulder pain. Left shoulder range of motion was limited due to pain in all planes with flexion 140 degrees, abduction 150 degrees, extension 40 degrees, and internal/external rotation 60 degrees. Orthopedic testing documented positive impingement, Neer's, Hawkin's-Kennedy, Codman drop arm, and empty can tests on the left. The treatment plan requested a left shoulder MRI with contrast and physical therapy 2x4 for the left shoulder, to improve strength, stability, range of motion and decrease pain. There were requests dated 1/15/14 for left shoulder surgery and post-operative physical therapy. There is no indication in the records that the surgery was certified. The 1/31/14 utilization review non-certified the request for post-operative physical therapy as there was no indication that the surgery had been authorized to warrant this request.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**POST-OP PHYSICAL THERAPY FOR THE LEFT SHOULDER, 2 TIMES A WEEK FOR 6 WEEKS: Upheld**

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

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

**Decision rationale:** Under consideration is a request for post-operative physical therapy 2 times per week for 6 weeks for the left shoulder. The California MTUS Post-Surgical Treatment Guidelines for rotator cuff repair/acromioplasty suggest a general course of 24 post-operative visits over 14 weeks during the 6-month post-surgical treatment period. If it is determined that additional functional improvement can be accomplished after completion of the general course of therapy, physical medicine treatment may be continued up to the end of the postsurgical physical medicine period. Guideline criteria have not been met. There is no indication that the patient has been authorized for the requested left shoulder surgery. There was no detailed documentation that conservative treatment had failed as physical therapy was requested on 1/6/14 and surgery on 1/15/14. There was no clear imaging evidence of rotator cuff deficit as the radiologist had recommended an MR arthrogram and this was requested concurrent to the surgery. In the absence of a surgical authorization, this request for post-operative physical therapy 2 times per week for 6 weeks for the left shoulder is not medically necessary.