

<b>Case Number:</b>	CM14-0135647		
<b>Date Assigned:</b>	08/29/2014	<b>Date of Injury:</b>	08/31/2011
<b>Decision Date:</b>	10/23/2014	<b>UR Denial Date:</b>	07/18/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	08/22/2014

### 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 Physical Medicine and rehabilitation, has a subspecialty in Pain Management 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 64-year-old male with a 08/31/2011 date of injury, due to cumulative trauma. s/p rotator cuff repair on 4/2012. The 7/18/14 determination was non-certified. The prior determination noted that the patient had 14 approved physical therapy visits. The report was incomplete and the reason for non-certification was not included for review. 7/7/14 progress report identified left shoulder pain moderate to severe, aggravated with movement. Exam revealed pain with ROM extremes and decreased range of motion. However, the specific measurements are not clear as there are two musculoskeletal exams documented, each with range of motion measurement, which differ from each other. One describes significant decrease in range of motion, the other has near to normal measurements. 6/9/14 left shoulder MR arthrogram report revealed prior rotator cuff repair. No evidence of full-thickness rotator cuff tear. Cleft of high signal contrast in between the superior and posterosuperior labrum and the glenoid, compatible with a tear. The anterosuperior labrum is essentially absent and the MGHL is not visualized. Prior biceps tenodesis and mild degenerative changes of the acromioclavicular joint.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Physical therapy 2 times a week for 6 weeks for the left shoulder, quantity 12.:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Physical medicine Page(s): 99. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Shoulder (updated 04/25/14), Physical therapy.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 2 General Approach to Initial Assessment and Documentation, Chronic Pain Treatment Guidelines CA MTUS 2009 9792.24.2. Page(s): 98-99.

**Decision rationale:** The California MTUS stresses the importance of a time-limited treatment plan with clearly defined functional goals, frequent assessment and modification of the treatment plan based upon the patient's progress in meeting those goals, and monitoring from the treating physician regarding progress and continued benefit of treatment is paramount. The patient has continued shoulder pain and apparent functional deficits, although these are not clearly documented. Records indicate that the patient had 14 prior physical therapy sessions authorized. There was no documentation indicating if these were completed and when. There was also no indication of any improvement following these sessions. It was not clear if the patient was following a home exercise program or if there were any barriers that would impede such. The medical necessity was not substantiated.