

<b>Case Number:</b>	CM14-0150718		
<b>Date Assigned:</b>	09/19/2014	<b>Date of Injury:</b>	03/11/2013
<b>Decision Date:</b>	10/31/2014	<b>UR Denial Date:</b>	08/21/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	09/16/2014

### 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 Internal Medicine, has a subspecialty in Pulmonary Diseases 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 injured worker is a 52-year-old male with a reported injury on 03/11/2013. The mechanism of injury was a 15 foot fall. The injured worker's diagnoses included cervicalgia, chronic cervical strain, multilevel cervical degenerative disk disease with disk bulges and foraminal narrowing, lumbago, chronic lumbosacral strain, L5/S1 anterolisthesis with chronic pars defects, and L4-L5/L5/S1 facet arthropathy, and status post left shoulder arthroscopy. The injured worker's past treatments included a home exercise program, postop physical therapy including 49 documented physical therapy visits between 04/04 and 08/18/2014, and icing of the left shoulder. The injured worker's diagnostic testing included a forward view x-ray of left shoulder on 01/21/2014, and a MRI of left shoulder on 04/11/2013 which showed a re-tear of the supraspinatus and moderate shoulder arthrosis. The injured worker also had an upper extremity NCV and EMG on 06/13/2013. The injured worker's surgical history included a prior left shoulder surgery in 1995, and on 02/12/2014 an arthroscopy of the left shoulder was subacromial decompression, Mumford resection, and revision rotator cuff repair with lysis of adhesions. The injured worker was evaluated on 08/05/2014 for evaluation of his left shoulder 24 weeks status post arthroscopy. The clinician indicated that the incisions were healing well, there was no swelling or bruising, the neurovascular exam was intact, range of motion was measured at flexion 170 degrees, abduction 160 degrees, internal rotation "L1", and the external rotation 40 degrees. On supine he had 55 degrees of external rotation, and 70 degrees of internal rotation. The contralateral shoulder had full range of motion and strength. The clinician indicated in his plan that the injured worker was better, but remained stiff regarding his supine rotation including both external and internal rotation, and recommended supervised physical therapy twice per week for 6 weeks. The injured worker was also evaluated 06/27/2014 where the clinician observed and reported left shoulder flexion at 170, abduction at 170, internal rotation "L1", and

external rotation at 30. Supine external rotation was measured at 45, and internal rotation at 70. The documentation provided did not indicate that the injured worker was taking any medications. The request was for additional physical therapy left shoulder 2 times a week for 6 weeks (12). No rationale for this request was provided. The Request for Authorization Form was not provided.

### **IMR ISSUES, DECISIONS AND RATIONALES**

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

**Additional physical therapy left shoulder 2 times a week for 6 weeks (12): Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS Postsurgical Treatment Guidelines.

**Decision rationale:** The request for additional physical therapy left shoulder 2 times a week for 6 weeks (12) is not medically necessary. The injured worker continued to complain of left shoulder pain approximately 24 weeks status post arthroscopy of the left shoulder. The California MTUS postsurgical treatment guideline recommends 24 physical therapy visits over 14 weeks for arthroscopic treatment of the rotator cuff. The postsurgical physical medicine treatment period is 6 months. The injured worker has exceeded the recommended number of physical therapy visits. The injured worker has made significant postsurgical progress, and should continue his home exercise program. Therefore, the request for additional physical therapy left shoulder 2 times a week for 6 weeks (12) is not medically necessary.