

<b>Case Number:</b>	CM14-0157339		
<b>Date Assigned:</b>	09/30/2014	<b>Date of Injury:</b>	02/25/2013
<b>Decision Date:</b>	12/18/2014	<b>UR Denial Date:</b>	08/21/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	09/25/2014

### 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 & Rehabilitation, and is licensed to practice in Illinois. 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 45-year-old female with a reported date of injury of 02/25/2013. The mechanism of injury was not stated. The current diagnoses include partial rotator cuff tear, persistent left shoulder pain status post arthroscopy and decompression, right elbow lateral epicondylitis, and chronic cervical strain. The injured worker was evaluated on 07/17/2014 with complaints of persistent neck pain and stiffness. The injured worker reported trouble reaching overhead, catching in the left shoulder, and tingling in the left forearm. The current medication regimen includes Tylenol. It is noted that the injured worker is unable to receive steroid injections due to a previous reaction. The physical examination of the right shoulder revealed positive impingement sign and normal strength with full motion. Physical examination of the left shoulder revealed 90% motion with mild weakness and discomfort in all directions. The treatment recommendations at that time included physical therapy. There was no Request for Authorization Form submitted for this review.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Physical therapy 3x4 for the left shoulder:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Physical Therapy.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 98-99.

**Decision rationale:** The California MTUS Guidelines state that active therapy is based on the philosophy that therapeutic exercise and/or activity are beneficial for restoring flexibility, strength, endurance, function, range of motion, and can alleviate discomfort. The Official Disability Guidelines state that physical medicine treatment for rotator cuff tear or impingement syndrome includes 10 visits over 8 weeks. It is noted that the injured worker is status post arthroscopy and subacromial decompression of the left shoulder. However, the injured worker has completed a previous course of postoperative physical therapy. The medical necessity for an additional 12 sessions has not been established. An additional 12 sessions would also exceed guideline recommendations. Therefore, the request is not medically appropriate.