

<b>Case Number:</b>	CM14-0026828		
<b>Date Assigned:</b>	06/13/2014	<b>Date of Injury:</b>	05/20/2009
<b>Decision Date:</b>	07/25/2014	<b>UR Denial Date:</b>	02/05/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	03/03/2014

### 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 Interventional Spine 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 patient is a 59 year old with an injury date on 5/20/09. Based on the 12/18/13 progress report provided by [REDACTED] the diagnoses are: 1. impingement syndrome right shoulder with cuff tear. 2. labral tear, right shoulder. 3. acromioclavicular arthrosis. Exam on 12/18/13 showed weakness of rotator cuff strength on the right shoulder. Pain with pressure in subacromial bursa and subdeltoid bursa on the right. There is no pain with palpation of the acromioclavicular joint, bilaterally, subacromial bursa on the left, coracoid process, bilaterally, bidpital groove, bilaterally or subdeltoid bursa on the left. Impingement sign, Hawkin's sign, and drop arm test positive on the right. Range of motion slightly limited particularly on internal rotation at 40/90 degrees. There is crepitus on range of motion of right shoulder. [REDACTED] is requesting twelve rehab (physical therapy) treatment visits. The utilization review determination being challenged is dated 2/5/14 and rejects request as prior physical therapy was not effective, and guidelines recommend an initial trial of 6 sessions of physiotherapy. [REDACTED] is the requesting provider, and he provided treatment reports from 9/16/13 to 6/5/14.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**TWELVE REHAB (PHYSICAL THERAPY) TREATMENT VISITS:** Overturned

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

**MAXIMUS guideline:** Decision based on MTUS Postsurgical Treatment Guidelines Page(s): 26-27.

**Decision rationale:** This patient presents with severe right shoulder pain. The treater has asked for twelve rehab (physical therapy) treatment visits but the request for authorization was not included in provided reports. On 12/18/13 patient's orthopedic physician has requested a right shoulder arthroscopy. MTUS guidelines state for rotator cuff syndrome/Impingement syndrome and arthroscopic shoulder surgery, post surgical treatment of 24 visits over 14 weeks is recommended over a treatment period of 6 months. In this case, the treater has requested 12 postoperative physical therapy visits for a planned shoulder arthroscopic surgery which is reasonable and within MTUS guidelines. The request is medically necessary.