

<b>Case Number:</b>	CM14-0027664		
<b>Date Assigned:</b>	06/13/2014	<b>Date of Injury:</b>	09/29/2012
<b>Decision Date:</b>	07/21/2014	<b>UR Denial Date:</b>	02/20/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	03/04/2014

### 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 and Pain Medicine 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 61-year-old male patient who sustained an industrial injury on 09/29/2012. The mechanism of injury was not described in the provided records. Diagnoses include right shoulder rotator cuff tear, right shoulder impingement syndrome, left shoulder partial thickness rotator cuff tear, left shoulder impingement syndrome, cervical spine myelogram and to sprain/strain, cervical discopathy, lumbar spine myoligamentous brain/strain, and lumbar discopathy. Previous conservative treatment included physical therapy, chiropractic care, acupuncture, anti-inflammatory medications. On 03/13/14, objective findings noted tenderness to direct palpation over the cervical spinous processes. There was tenderness in the upper trapezius region bilaterally. Cervical range of motion was restricted with pain. Shoulder examination revealed pain with palpation to the subacromial bursa and subdeltoid bursa bilaterally. Impingement sign and Hawkins tests were positive bilaterally. Shoulder range of motion was restricted bilaterally. Reference to an MRI of the right shoulder performed on 10/17/13 reportedly showed a full-thickness rotator cuff tear and tendinosis. Reference to MRI of the left shoulder performed 10/17/13 reportedly showed tendinosis of the rotator cuff and subscapularis bursitis. Patient was prescribed Norco 10/325 mg #60 to be taken every 6 hours as needed for postoperative analgesic medication. It was noted the patient is scheduled for surgery on 03/21/14. Operative report dated 03/21/14 noted the patient underwent right shoulder arthroscopic rotator cuff repair, arthroscopic subacromial decompression/partial anterior acromioplasty, extensive bursectomy of subacromial space, subtotal synovectomy, glenohumeral joint. A previous request for 15 postop physical therapy sessions was modified at utilization review dated 02/21/14 to certify 12 post-operative physical therapy sessions, citing guidelines indicating an initial trial of 12 sessions was recommended for this condition and with ongoing

documentation of not only subjective improvement but objective/functional improvement, additional sessions may be warranted totaling up to 24 sessions over 14 weeks.

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

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

#### **15 POST-OP PHYSICAL THERAPY SESSIONS: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation OFFICIAL DISABILITY GUIDELINES (ODG), Physical Therapy (PT).

**Decision rationale:** The ODG Physical therapy guidelines state "Allow for fading of treatment frequency (from up to 3 visits per week to 1 or less), plus active self-directed home PT....Rotator cuff syndrome/Impingement syndrome (ICD9 726.1; 726.12): Post-surgical treatment, arthroscopic: 24 visits over 14 weeks." Records indicate the patient underwent a right shoulder arthroscopic rotator cuff repair and subacromial decompression/partial anterior acromioplasty on 03/21/14. 15 sessions of postoperative physical therapy were requested. Guidelines indicate that if postsurgical physical medicine is medically necessary, an initial course of therapy may be prescribed, and with documentation of functional improvement, a subsequent course of therapy shall be prescribed within the parameters of the general course of therapy applicable to the specific surgery. Therefore, an initial 15 postoperative physical therapy sessions would not be considered medically necessary; however, 12 postoperative physical therapy sessions would be considered medically necessary with consideration for additional treatment pending documentation of objective/functional gains and progression towards goals. Thus, 15 postoperative physical therapy sessions (body part not identified) is not medically necessary and this request is not medically necessary and appropriate.