

<b>Case Number:</b>	CM14-0097627		
<b>Date Assigned:</b>	09/23/2014	<b>Date of Injury:</b>	03/12/2006
<b>Decision Date:</b>	10/24/2014	<b>UR Denial Date:</b>	05/27/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	06/23/2014

### 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 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 68-year-old male who reported injury on 03/12/2006. The mechanism of injury was not provided. The injured worker's diagnosis included status post arthroscopic rotator cuff repair. The injured worker's past treatments included surgery, medications, and physical therapy. The injured worker's diagnostic testing included an official MRI on 06/25/2013 of the left shoulder. The injured worker has left shoulder full thickness rotator cuff tear status post arthroscopic rotator cuff repair on 10/14/2013. On the clinical note dated 05/15/2014, the injured worker complained of left shoulder pain and stiffness. The injured worker had left shoulder range of motion with forward flexion to 135 degrees, abduction to 120 degrees, and internal rotation to the SI joint, all with stiffness and pain in all directions. The injured worker's medications include Percocet 7.5/350 mg and ibuprofen 800 mg. The request was for additional postop PT 2x6. The rationale for the request is continued deficits in range of motion and strength of the shoulder. The Request for Authorization form was not submitted for review.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Additional Post-op PT 2x6:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, shoulder procedure summary

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

**Decision rationale:** The request for additional postop PT 2x6 is not medically necessary. The injured worker is diagnosed with status post arthroscopic rotator cuff repair. The injured worker complained of pain and stiffness to the left shoulder. The California MTUS Guidelines recommend 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 guidelines recommend postsurgical treatment for rotator cuff as 24 visits over 14 weeks, with a postsurgical physical medicine treatment period of 6 months. The injured worker has completed 24 visits of postop physical therapy, and has forward flexion to 135 degrees, abduction to 120 degrees, and internal rotation to the SI joint, which was 135 flexion and 105 abduction on 03/20/2014. There is a lack of documentation that indicates objective functional deficits to warrant additional visits of physical therapy. Additionally, the request does not indicate the location of the body for physical therapy. As such, the request for additional postop PT 2x6 is not medically necessary.