

<b>Case Number:</b>	CM14-0189679		
<b>Date Assigned:</b>	11/20/2014	<b>Date of Injury:</b>	09/18/2012
<b>Decision Date:</b>	01/08/2015	<b>UR Denial Date:</b>	11/12/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	11/12/2014

### 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 Neurology 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 58 year-old male with a date of injury recorded as 9/18/2012. The injury is reported as a right rotator cuff tear. A right rotator cuff repair was performed on 3/13/2013, and a debridement/repeat arthroscopy was performed on 10/11/2013. The IW is status post a reverse right shoulder arthroplasty which was performed on 4/30/2014. Medical records including Primary Treating Physician Progress Reports, Orthopedic consultations and post-surgical follow-up reports from dates 4/30/2014 until 11/13/2014 indicate that the IW continues to report significant pain complaints (rated as 9 out of 10) to the bilateral shoulders, neck, and thoracic spine, with radiating pain, numbness, and tingling complaints to the right upper extremity. Physical examinations reveal moderate to severe limitations of range of motion in cervical and thoracic spine in all planes tested, as well as in the left and right shoulder joints. Upper extremity motor strength is decreased, noted recently as 3/5. Physical exam findings are consistent to report positive cervical maximum compression test and positive shoulder depression tests bilaterally. An EMG/NCS of the right upper extremity is reported as unremarkable in a summary given by a treating physician in a note dated 9/18/2014, with no evidence of neuropathy, radiculopathy or plexopathy. Radiographs on 9/18/2014 reveal that the reverse shoulder prosthesis is satisfactorily positioned without signs of loosening or failure and without significant changes from previous examinations. An MRI of the left shoulder conducted on 4/21/2014 is significant for multiple "chronic" tears in the supraspinatus, infraspinatus, and subscapularis tendons with note of severe glenohumeral osteoarthritis and severe acromioclavicular degenerative joint disease - though none of the treatment plans included for review include mention treatment specific to the left shoulder. Records indicate that the IW received 16 sessions of physical therapy for the right shoulder between the dates of 7/28/2014 and 10/22/2014, with progress notes from his various treating physicians noting that

the IW's pain complaints and physical exam findings remain grossly unchanged during this period. A request for authorization for an additional 24 physical therapy sessions (three-times weekly over eight weeks duration) was submitted on 9/23/2014 and was subsequently non-certified in a Utilization Review dated 11/12/2014.

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

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

**Physical therapy three times a week for eight weeks for cervical, thoracic and shoulder:**  
Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints, Postsurgical Treatment Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 165-172, Postsurgical Treatment Guidelines Page(s): 26-27.

**Decision rationale:** The Post -surgical treatment guidelines within the MTUS state that physical medicine is recommended within the post-surgical treatment period of 6 months following arthropathy. During this time, 24 visits over 10 weeks duration are appropriate following surgery (Shoulder, p. 26 - 27). In this case, the IW has received 16 such treatments, and the request for an additional 24 would exceed the number recommended by the MTUS by six. In regard to the cervical and thoracic pain complaints, the ACOEM Guidelines (Chapter 8, Neck and Upper Back complaints) indicate that specific neck exercises for range of motion and strengthening are recommended, allowing for 1 - 2 physical therapy visits for education, counseling and evaluation of a home exercise plan (Table 8-5. Methods of Symptom Control for Neck and Upper Back Complaints, p. 174). Nevertheless, the requested number of sessions requested to treat the IW's cervical and thoracic complaints exceeds the number recommended and is not medically necessary.