

<b>Case Number:</b>	CM14-0199835		
<b>Date Assigned:</b>	12/10/2014	<b>Date of Injury:</b>	10/30/2007
<b>Decision Date:</b>	02/20/2015	<b>UR Denial Date:</b>	11/18/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	12/01/2014

### 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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:  
 State(s) of Licensure: California, District of Columbia, Maryland  
 Certification(s)/Specialty: Anesthesiology, Pain Management

### CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

72y/o male injured worker with date of injury 10/30/07 with related right shoulder pain. Per progress report dated 10/8/14, the injured worker complained of right shoulder pain rated 6/10 in intensity. He was status post remote right shoulder rotator cuff repair 2010. Per physical exam, there was tenderness about the right shoulder. Range of motion was limited. Diagnoses included right shoulder impingement with rotator cuff arthropathy, status post remote right shoulder rotator cuff repair. Treatment to date has included surgery, physical therapy, and medication management. The date of UR decision was 11/18/14.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Physical Therapy 3 times per week times 4 weeks for Right Shoulder:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines-Treatment for Workers' Compensation, Online Edition Chapter: Shoulder (Acute & Chronic)

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder, Physical Therapy.

**Decision rationale:** Per the ODG physical therapy guidelines: Rotator cuff syndrome/Impingement syndrome (ICD9 726.1; 726.12):Medical treatment: 10 visits over 8 weeksSprained shoulder; rotator cuff (ICD9 840; 840.4):Medical treatment: 10 visits over 8 weeksThe documentation submitted for review indicates that the injured worker was previously treated with physical therapy. It was not indicated how many sessions were completed, nor the result. As the request exceeds the number of sessions recommended by the guidelines, medical necessity cannot be affirmed.