

<b>Case Number:</b>	CM14-0203696		
<b>Date Assigned:</b>	12/16/2014	<b>Date of Injury:</b>	04/03/2014
<b>Decision Date:</b>	02/19/2015	<b>UR Denial Date:</b>	11/10/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	12/05/2014

### 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  
Certification(s)/Specialty: Orthopedic Surgery

### 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 44 year old female with a work related injury dated 04/01/2014 after lifting heavy boxes for an entire day. According to a progress note dated 09/25/2014, the injured worker presented for a follow up for left shoulder with complaints of diffuse tenderness or pain to palpation throughout the shoulder region. Diagnoses included shoulder strain. Treatments have consisted of physical therapy and medications. Physical therapy visit dated 07/24/2014 consisted of evaluation, therapeutic activities, manual therapy, and kinesio tape. Diagnostic testing included MRI of left shoulder dated 08/28/2014 which revealed bursal sided supraspinatus fraying with a fraying and partial thickness tearing, long head biceps tendinosis, and narrowed osseous acromial outlet. Work status is noted as modified. On 11/10/2014, Utilization Review non-certified the request for Post operative Physical Therapy 2xwk x 6wks for Left Shoulder citing California Medical Treatment Utilization Schedule Postsurgical Treatment Guidelines. The Utilization Review physician stated there is no indication that the surgery has been approved. Therefore, the Utilization Review decision was appealed for an Independent Medical Review.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Post-operative physical therapy 2 times a week for 6 weeks for the left shoulder:**  
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:** Per the CA MTUS Post Surgical Treatment Guidelines, Shoulder, pages 26-27 state the recommended amount of postsurgical treatment visits allowable are: Sprained shoulder; rotator cuff (ICD9 840; 840.4): Postsurgical treatment (RC repair/acromioplasty): 24 visits over 14 weeks Postsurgical physical medicine treatment period: 6 months The guidelines recommend "initial course of therapy" to mean one half of the number of visits specified in the general course of therapy for the specific surgery in the postsurgical physical medicine treatment recommendations set forth in the guidelines. In this case, the request is for 12 visits which are the allowable in the guidelines. Therefore, the request is medically necessary. This review presumes that a surgery is planned and will proceed. There is no medical necessity for this request if the surgery does not occur.