

<b>Case Number:</b>	CM14-0209322		
<b>Date Assigned:</b>	12/22/2014	<b>Date of Injury:</b>	06/20/2011
<b>Decision Date:</b>	02/13/2015	<b>UR Denial Date:</b>	12/01/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	12/15/2014

### 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 Orthopedic Surgery 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:

MTUS identifies documentation of failure to increase range of motion and strength of the musculature around the shoulder even after exercise programs and failing conservative therapy for three months including cortisone injections, as criteria necessary to support the medical necessity of subacromial decompression. ODG identifies documentation of conservative care: recommend 3 to 6 months; subjective clinical findings: pain with active arc motion 90 to 130 degrees and pain at night (tenderness over the greater tuberosity is common in acute cases); objective clinical findings: weak or absent abduction; may also demonstrate atrophy and tenderness over rotator cuff or anterior acromial area and positive impingement sign and temporary relief of pain with anesthetic injection (diagnostic injection test); imaging clinical findings: conventional x-rays, ap, and true lateral or axillary view and gadolinium MRI, ultrasound, or arthrogram showing positive evidence of deficit in rotator cuff, as criteria necessary to support the medical necessity of subacromial decompression. Within the medical information available for review, there is documentation of diagnoses of clinical and MRI evidence of a large, near full thickness tear of the rotator cuff of the right shoulder. In addition, there is documentation of conservative care for 3 to 6 months, subjective clinical findings (weakness of his right shoulder to external rotation with severe pain with overhead activities), and objective clinical findings (global tenderness about his right shoulder with weakness to external rotation and temporary relief of pain with anesthetic injection (diagnostic injection test)). However, despite the 11/6/14 medical report's reported imaging findings (MRI shows a near full thickness tear of the rotator cuff), there is no documentation of an imaging report. Therefore, based on guidelines and a review of the evidence, the request for anchors and screws, OPA right shoulder PASTA repair, acromioplasty, biceps tendon tenodesis is not medically necessary.

## IMR ISSUES, DECISIONS AND RATIONALES

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

**Post-operative physical therapy for the right shoulder, three times weekly for four weeks:**

Upheld

**Claims Administrator guideline:** Decision based on MTUS Postsurgical Treatment Guidelines.

**MAXIMUS guideline:** Decision based on MTUS Postsurgical Treatment Guidelines Page(s): 27. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Shoulder, Physical Therapy (PT); Title 8, California Code of Regulations, section 9792.20.

**Decision rationale:** MTUS Postsurgical Treatment Guidelines identifies up to 24 visits of post-operative physical therapy over 14 weeks and post-surgical physical medicine treatment period of up to 6 months. In addition, MTUS postsurgical treatment Guidelines identifies that the initial course of physical therapy following surgery is 1/2 the number of sessions recommended for the general course of therapy for the specified surgery. MTUS-Definitions identifies that any treatment intervention should not be continued in the absence of functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications or medical services. ODG identifies that when treatment requests exceeds guideline recommendations, the physician must provide a statement of exceptional factors to justify going outside of guideline parameters. Within the medical information available for review, there is documentation of diagnoses of clinical and MRI evidence of a large, near full thickness tear of the rotator cuff of the right shoulder. However, there is no documentation of a pending surgery that has been authorized/certified. In addition, the requested post-operative physical therapy for the right shoulder, three times weekly for four weeks exceeds guidelines (for an initial trial). Therefore, based on guidelines and a review of the evidence, the request for post-operative physical therapy for the right shoulder, three times weekly for four weeks is not medically necessary.