

<b>Case Number:</b>	CM15-0001050		
<b>Date Assigned:</b>	01/12/2015	<b>Date of Injury:</b>	08/21/2011
<b>Decision Date:</b>	03/11/2015	<b>UR Denial Date:</b>	12/18/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	01/05/2015

### 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: Physical Medicine & Rehabilitation

### 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 patient is a 46 year old female with an injury date on 8/21/11. The patient complains of left shoulder pain rated 8/10 per 11/3/14 report. The patient is taking Tramadol which facilitates average 4-5 point decrease on a scale of 10 per 11/3/14 report. The patient also has right knee pain rated 5/10, and right elbow pain rated 5/10 per 9/15/14 report. Based on the 11/3/14 progress report provided by the treating physician, the diagnoses are: 1. left shoulder impingement with rotator cuff tear and acromioclavicular osteoarthopathy. 2. SLAP lesion left shoulder. 3. adhesive capsulitis, left shoulder pain. 4. right knee internal derangement. A physical exam on 9/15/14 showed "tenderness to palpation of left shoulder anterior aspect. Left shoulder range of motion is restricted." The patient's treatment history includes medications, physical therapy, cryotherapy, home exercise program. The treating physician is requesting physical therapy 3 times a week for 4 weeks for the left shoulder. The utilization review determination being challenged is dated 12/18/14. The requesting physician provided treatment reports from 7/28/14 to 11/3/14.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Physical therapy 3 times a week for 4 weeks for the left shoulder:** Overturned

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** Decision based on MTUS Postsurgical Treatment Guidelines Page(s): 26-27.

**Decision rationale:** This patient presents with left shoulder pain. The treater has asked for PHYSICAL THERAPY 3 TIMES A WEEK FOR 4 WEEKS FOR THE LEFT SHOULDER on 11/3/14. The request is for 'continue postoperative physical therapy left shoulder, 3 times per week for 4 weeks.' The patient has been approved for a left shoulder surgery for a rotator cuff tear and SLAP lesion per 11/3/14 report. MTUS guidelines state for rotator cuff syndrome/Impingement syndrome and arthroscopic shoulder surgery, post surgical treatment of 24 visits over 14 weeks is recommended over a treatment period of 6 months. In this case the patient is approved for a left shoulder arthroscopic surgery. There is no record of recent physical therapy sessions. The requested 12 sessions of postoperative physical therapy for the left shoulder appear to be within MTUS guidelines for the patient's upcoming surgery. The request IS medically necessary.