

<b>Case Number:</b>	CM15-0109528		
<b>Date Assigned:</b>	06/16/2015	<b>Date of Injury:</b>	04/20/2014
<b>Decision Date:</b>	07/14/2015	<b>UR Denial Date:</b>	05/14/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	06/08/2015

### 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 injured worker is a 46 year old female with an industrial injury dated 04/20/2014 resulting in an injury to the right shoulder. Her diagnoses included right shoulder parascapular myofascial pain, right shoulder subacromial bursitis, right shoulder biceps tendinitis and status post right shoulder arthroscopic subacromial decompression and open sub pectoral muscle transfer on 01/26/2015. Prior treatment included physical therapy, anti-inflammatory medications, lidocaine challenge, right shoulder subacromial corticosteroid injection and surgery. She presents on 04/30/2015 post-surgery and reports that her pain has improved. She rates it at a level of 0-4 out of 10 intermittently with dull achiness. She denies any numbness, tingling or swelling. Physical exam showed well healed arthroscopy portals with mildly positive Hawkins. There was no tenderness to palpation over the bicipital groove or AC joint. She had full passive glenohumeral range of motion. Grip strength was normal. Sensation was grossly normal to light touch. Treatment plan included to have the injured worker increase her workplace activities, remain engaged in physical therapy and follow up in 1 month. The injured worker was to limit overhead work and limit lifting to 10 pounds. The treatment request is for continued post-operative physical therapy to the right shoulder, twice a week for six weeks.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Continued Post Operative Physical Therapy to the right shoulder, twice a week for six weeks:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Post-surgical Therapy for Shoulder; 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.

**Decision rationale:** The patient is s/p shoulder arthroscopy on 1/26/15, over 5 months ago. The Chronic Pain Guidelines allow for physical therapy with fading of treatment to an independent self-directed home program. The employee has received 22 PT visits of the 24 authorized without specific demonstrated clinical deficits or functional limitations to allow for additional therapy treatments. Post-surgical guidelines allow for up to 24 visits post arthroscopic rotator cuff repair over 14 weeks over a 6 month rehab period. The patient is without tenderness, has full passive shoulder range with 5/5 motor strength and negative orthopedic testing to support further therapy as the patient should have been transitioned to an independent home exercise program. There is no ADL limitations noted or extenuating circumstances to allow for further therapy outside guidelines criteria. The Continued Post Operative Physical Therapy to the right shoulder, twice a week for six weeks is not medically necessary and appropriate.