

<b>Case Number:</b>	CM15-0142387		
<b>Date Assigned:</b>	08/03/2015	<b>Date of Injury:</b>	05/23/2013
<b>Decision Date:</b>	08/28/2015	<b>UR Denial Date:</b>	07/13/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	07/22/2015

### 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: Massachusetts

Certification(s)/Specialty: Physical Medicine & Rehabilitation, 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:

The injured worker is a 44 year old male, who sustained an industrial injury on 5-23-2013. The medical records submitted for this review did not include the details regarding the initial injury or prior treatments to date. Diagnoses include left shoulder rotator cuff tendinitis and bursitis, rule out tear; status post left shoulder arthroscopy. Currently, he complained of left shoulder pain with limited range of motion and instability. On 6-25-15, the physical examination documented tenderness to the shoulder region including the pectoralis area with weakness and restricted range of motion. The plan of care included eight physical therapy sessions twice a week for four weeks.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Physical therapy for the left shoulder, 2 x 4: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Page(s): 99-100, Postsurgical Treatment Guidelines.

**MAXIMUS guideline:** Decision based on MTUS Postsurgical Treatment Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) (1) Chronic pain, Physical medicine treatment. (2) Preface, Physical Therapy Guidelines.

**Decision rationale:** The claimant sustained a work injury in May 2013 and underwent and arthroscopic acromioplasty with labral repair in May 2014. Treatments included postoperative physical therapy. When seen, he was having intermittent moderate left shoulder pain. Physical examination findings included shoulder tenderness with decreased range of motion and rotator cuff weakness. Authorization for eight physical therapy treatment sessions was requested. Physical therapy following the surgery performed would be expected to consist of up to 24 treatments over a 14 week period of time with a 6 month post-surgical physical medication treatment period. The claimant has already had post-operative physical therapy and the physical medicine treatment period has been exceeded. The claimant is being treated under the chronic pain guidelines. In terms of physical therapy treatment for chronic pain, guidelines recommend a six visit clinical trial with a formal reassessment prior to continuing therapy. In this case, the number of visits requested is in excess of that recommended or what might be needed to reestablish or revise the claimant's home exercise program. Skilled therapy in excess of that necessary could promote dependence on therapy provided treatments. The request is not medically necessary.