

<b>Case Number:</b>	CM14-0176095		
<b>Date Assigned:</b>	10/28/2014	<b>Date of Injury:</b>	04/23/2013
<b>Decision Date:</b>	12/04/2014	<b>UR Denial Date:</b>	10/17/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/22/2014

### 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 Physical Medicine and Rehabilitation, has a subspecialty in Neuromuscular Medicine and is licensed to practice in Maryland. 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:

The patient is a 54 year old male who had a work injury dated 4/23/13. The diagnoses include left shoulder pain; status post left shoulder labral repair and partial cuff repair with biceps tenodesis performed on 5/16/2014. Under consideration are requests for 12 physical therapy visits. There is a 9/18/14 progress report which states that the patient is here for follow-up on his left shoulder superior arthroscopic acromioplasty, Mumford procedure, debridement of SLAP tear and biceps tenodesis, open subpectoral biceps tenodesis, and debridement of partial thickness cuff tears, done on 5 / 16/ 14. He also has developed swelling and pain of his left thumb and long fingers. He has completed 24 postoperative physical therapy sessions. He states he is about 50% improved. His pain is sharp and dull. It wakes him from a sound sleep and his shoulder is catching on occasion. He also has neck pain and radiculopathy which is to be evaluated by a neurosurgeon. He still has significant pain and is on Norco 7.5/325. He has significant stiffness of his hand and limitation of hand closure. On examination the patient is a well-developed Caucasian male looking his stated age. He walks with an antalgic gait. He lacks 25% of cervical extension. He has a positive Spur ling's test and lateral bending test. Shoulder range of motion (left/right) is elevation 50/160, abduction 40/160, internal rotation SI joint/TS, and abduction 10/60. Passive range of motion of the left shoulder is elevation 90, abduction 85, external rotation 40, internal rotation 50 and abduction 40. He has full range of motion of bilateral elbows, forearms, and wrists. He has swelling of his left hand and limitation of closure, missing the distal palmar crease on closure by 4.5 cm, the mid palmar crease by 3 cm. X-rays of his left shoulder were done. AP of the glenoid in internal and external rotation show a well reduced glenohumeral joint. There is an Endobutton in the bicipital groove consistent with biceps tenodesis. The assessment states that this patient is a truck driver who had a very significant

injury of his shoulder. His work involves overhead activities and lifting. He was involved primarily in a passive range of motion exercises for the first 3 months. He has been doing active range of motion exercises for 1 month. Despite that, if one compares the physical therapy note of September 16, 2014 to that of August 15, 2014, there is improvement in passive range of motion, with improved 20 of abduction, 25 of external rotation. He had no active range of motion in August. The treatment plan states that this is an unusual case because of the extensiveness of his injury. He has a very physically demanding occupation which requires a lot of overhead activities and strength. He has some swelling of his hand, which can be associated with shoulder surgery and may be indicative of perhaps low-grade RSD. Given the complexity of his shoulder problem and its corresponding hand swelling and stiffness, and the nature of his work, further physical therapy is indicated. The most recent PT note dated 9/16/14 states that Hand symptoms are suspicious for cervical involvement and that the patient is awaiting authorization by neurologist/spine Specialist. He continues to report high pain levels. Pain scale rating lasted 24 hours = 6-8/10 (no meds). Hand Issues continue (numbness/pain).

### **IMR ISSUES, DECISIONS AND RATIONALES**

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

#### **12 Physical therapy visits: Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines physical medicine Page(s): 98-99, Postsurgical Treatment Guidelines Page(s): 11. Decision based on Non-MTUS Citation Other Medical Treatment Guideline or Medical Evidence: Title 8, California Code of Regulations, section 9792.20 et seq. page 1

**Decision rationale:** 12 Physical Therapy visits are not medically necessary per the MTUS Guidelines. The guidelines recommend up to 24 visits post surgically for this condition. The MTUS guidelines recommend a fading of therapy to an active self directed home exercise program. The documentation indicates that patient has not had significant levels of functional improvement as defined by the MTUS despite having this therapy. Additionally, the documentation indicates that the patient is having cervical radicular symptoms that may be hindering therapy and is to see a neurosurgeon. The request as written is not specific as to which body part the therapy is for. The request for 12 Physical Therapy visits are not medically necessary.