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| <b>Case Number:</b>   | CM14-0182288 |                              |            |
| <b>Date Assigned:</b> | 11/07/2014   | <b>Date of Injury:</b>       | 08/02/2013 |
| <b>Decision Date:</b> | 12/17/2014   | <b>UR Denial Date:</b>       | 10/20/2014 |
| <b>Priority:</b>      | Standard     | <b>Application Received:</b> | 11/03/2014 |

### 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 & Rehabilitation 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:

This is a 60-year-old male with an 8/2/13 date of injury, when she fell on her right shoulder. The patient was seen on 9/16/14 with complaints of significant pain in the right shoulder. Exam findings of the right shoulder revealed abduction and external rotation of 45 degrees and forward flexion of 90 degrees. There was tenderness over the right lateral epicondyle. The note stated that the patient would proceed with an arthroscopy of the right shoulder. The diagnosis is adhesive capsulitis of the right shoulder/rule out rotator cuff tear; right lateral epicondylitis; rule out carpal tunnel syndrome and myofascial pain. Treatment to date: cortisone injections, PT, chiropractic treatment, work restrictions and medications. An adverse determination was received on 10/20/14. The request for Physical Therapy 1 Time a Week for 24 Weeks on The Right Shoulder was modified to 24 sessions of PT over 14 weeks, given that the Guidelines recommended 14 weeks period of PT after the surgery.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Physical Therapy 1 Time A Week for 24 Weeks on The Right Shoulder:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Physical Therapy Page(s): 98-99. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder Chapter, PT

**Decision rationale:** CA MTUS stresses the importance of a time-limited treatment plan with clearly defined functional goals, frequent assessment and modification of the treatment plan based upon the patient's progress in meeting those goals, and monitoring from the treating physician regarding progress and continued benefit of treatment is paramount. In addition, ODG recommends 24 visits over 14 weeks for Post-surgical arthroscopic treatment for Rotator cuff syndrome/Impingement syndrome. However there is no rationale from the requesting physician indicating why the patient cannot accomplish her postoperative PT treatment in 14 weeks, what is the recommended time frame due to the Guidelines? In addition, the UR decision dated 10/20/14 modified the request and certified 24 sessions of PT for 14 weeks. Therefore, the request for Physical Therapy 1 Time a Week for 24 Weeks on The Right Shoulder was not medically necessary.