

<b>Case Number:</b>	CM14-0183625		
<b>Date Assigned:</b>	11/10/2014	<b>Date of Injury:</b>	07/13/2008
<b>Decision Date:</b>	12/12/2014	<b>UR Denial Date:</b>	10/01/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	11/04/2014

### 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 Orthopedic Surgery 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:

According to the records made available for review, this is a 49-year-old female with a 7/13/08 date of injury and repeat video arthroscopy of the right shoulder, repeat arthroscopic subacromial decompression and distal clavicle resection and arthroscopic rotator cuff repair due to a focal near full thickness rotator cuff tear of the anterolateral supraspinatus tendon of the right shoulder on 5/28/14. At the time (9/9/14) of the request for authorization for associated surgical service: Physical therapy x 24 (2 times a week for 12 weeks) visits for the right shoulder and associated surgical service: IF unit purchase with supplies, there is documentation of subjective (improvement of her right shoulder) and objective (approximately 90 degrees of flexion and abduction of her right shoulder) findings, current diagnoses (tendinitis, impingement syndrome, and arthritis of the right shoulder), and treatment to date (post-operative rehabilitative therapy). Regarding associated surgical service: Physical therapy x 24 (2 times a week for 12 weeks) visits for the right shoulder, the number of previous physical therapy treatments cannot be determined. In addition, there is no documentation of functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications as a result of previous physical therapy treatment. Regarding associated surgical service: IF unit purchase with supplies, there is no documentation of IF unit to be used in conjunction with recommended treatments and limited evidence of improvement on those recommended treatments alone.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Associated Surgical Service: Physical Therapy x 24 (2 times a week for 12 weeks) Visits for the Right Shoulder:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 203. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Shoulder Chapter

**MAXIMUS guideline:** Decision based on MTUS Postsurgical Treatment Guidelines Page(s): 27. Decision based on Non-MTUS Citation Other Medical Treatment Guideline or Medical Evidence: Title 8, California Code of Regulations, and Section 9792.20

**Decision rationale:** MTUS Postsurgical Treatment Guidelines identifies up to 24 visits of post-operative physical therapy over 14 weeks and post-surgical physical medicine treatment period of up to 6 months. In addition, MTUS postsurgical treatment Guidelines identifies that the initial course of physical therapy following surgery is 1/2 the number of sessions recommended for the general course of therapy for the specified surgery. MTUS-Definitions identifies that any treatment intervention should not be continued in the absence of functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications or medical services. Within the medical information available for review, there is documentation of a diagnosis of tendinitis, impingement syndrome, and arthritis of the right shoulder. In addition, there is documentation of status post repeat arthroscopic subacromial decompression and distal clavicle resection and arthroscopic rotator cuff repair due to a focal near full thickness rotator cuff tear of the anterolateral supraspinatus tendon of the right shoulder on 5/28/14. However, there is no documentation of the number of previous treatments to determine if guidelines have already been exceeded. In addition, there is no documentation of functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications as a result of previous physical therapy treatments. Therefore, based on guidelines and a review of the evidence, the request for the associated surgical service of physical therapy x 24 (2 times a week for 12 weeks) visits for the right shoulder is not medically necessary.

**Associated Surgical Service: IF Unit Purchase with Supplies:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 166, Chronic Pain Treatment Guidelines Interferential Current Stimulation (ICS) Page(s): 119-120. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back Chapter

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Interferential Current Stimulation (ICS) Page(s): 118-120.

**Decision rationale:** MTUS Chronic Pain Medical Treatment Guidelines identifies that interferential current stimulation is not recommended as an isolated intervention and that there is no quality evidence of effectiveness except in conjunction with recommended treatments, including return to work, exercise and medications, and limited evidence of improvement on those recommended treatments alone. Within the medical information available for review, there

is documentation of a diagnosis of tendinitis, impingement syndrome, and arthritis of the right shoulder. In addition, there is no documentation of IF unit to be used in conjunction with recommended treatments and limited evidence of improvement on those recommended treatments alone. Based on the guidelines, and a review of the evidence, the request for the associated surgical services is not medically necessary.