

<b>Case Number:</b>	CM15-0115390		
<b>Date Assigned:</b>	06/23/2015	<b>Date of Injury:</b>	09/02/2011
<b>Decision Date:</b>	07/23/2015	<b>UR Denial Date:</b>	05/27/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	06/15/2015

### 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, Indiana, Oregon  
 Certification(s)/Specialty: Orthopedic Surgery

### 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 a work related injury September 2, 2011. According to a primary treating physician's report, dated May 14, 2015, the injured worker presented for follow-up evaluation with complaints of pain in the neck, mid-upper back, lower back, left shoulder, and left elbow. He reports that physical therapy improved his function and activities of daily living by 10%. Objective findings of the cervical spine included; tenderness to palpation over the paraspinal muscles, restricted range of motion and compression test positive; thoracic spine tenderness to palpation over the paraspinal muscles with restricted range of motion; lumbar spine tenderness to palpation over the paraspinal muscles, restricted range of motion, and straight leg raise positive bilaterally; left shoulder tenderness with restricted range of motion, impingement and supraspinatus tests, positive; left elbow tenderness to palpation; left wrist tenderness to palpation, Tinel's sign and Phalen's test are positive. Diagnoses are cervical/thoracic/lumbosacral musculoligamentous sprain/strain with radiculitis; rule out cervical and lumbar spine discogenic disorder; left shoulder sprain/strain rotator cuff tear/impingement; left elbow sprain/strain; left wrist sprain/strain, carpal tunnel syndrome. Treatment plan included continued physical therapy and extracorporeal shockwave therapy. At issue, is the request for authorization for left shoulder arthroscopic subacromial decompression and rotator cuff repair, post-operative physical therapy, and continued physical therapy for the cervical, thoracic, lumbar spine, and left shoulder.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Left Shoulder Arthroscopic Subacromial Decompression and Rotator Cuff Repair: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 211.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 209-210.

**Decision rationale:** According to the CA MTUS/ACOEM Shoulder Chapter, page 209-210, surgical considerations for the shoulder include failure of four months of activity modification and existence of a surgical lesion. In addition, the guidelines recommend surgery consideration for a clear clinical and imaging evidence of a lesion shown to benefit from surgical repair. In this case there is no MRI report submitted for review to document the presence of a surgical lesion. The only reference is second hand via the record review portion of an AME. Based on this, the request is not medically necessary.

**12 Post Operative Physical Therapy treatments for the left shoulder 3 times a week for 4 weeks: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Postsurgical Treatment Guidelines.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 209-210.

**Decision rationale:** Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

**6 Continued physical therapy treatments for cervical, thoracic, lumbar spine and left shoulder 1 times a week for 6 weeks: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Physical medicine.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines physical medicine Page(s): 99.

**Decision rationale:** CA/MTUS Chronic Pain Treatment Guidelines, page 99 recommend physical therapy for chronic conditions as follows: Physical Medicine Guidelines: Allow for fading of treatment frequency (from up to 3 visits per week to 1 or less), plus active self-directed home Physical Medicine. Myalgia and myositis, unspecified: 9-10 visits over 8 weeks; Neuralgia, neuritis, and radiculitis, unspecified 8-10 visits over 4 weeks. In this case, 6 visits have been completed. The additional visits would exceed the guideline recommendations. Based on this, the request is not medically necessary.