

<b>Case Number:</b>	CM15-0071033		
<b>Date Assigned:</b>	04/21/2015	<b>Date of Injury:</b>	12/23/2011
<b>Decision Date:</b>	05/21/2015	<b>UR Denial Date:</b>	04/09/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	04/14/2015

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

### 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 59 year old female with an industrial injury dated 12/23/2011. Her diagnoses included shoulder pain, left rotator cuff syndrome and tenosynovitis, bicipital (left). Prior treatments included physical therapy, heat and medications. She presents on 04/06/2015 with complaints of left shoulder pain. Physical exam of left shoulder noted no swelling or deformity. Distal neurovascular status was intact to motor and sensory function. There was some mild tenderness in the left shoulder. Treatment plan included physical therapy and injection for pain relief.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Physical Therapy 2 times a week for 6 weeks left shoulder:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Physical medicine Page(s): 98-99, Postsurgical Treatment Guidelines Page(s): 26-27.

**Decision rationale:** The patient presents with pain in the left shoulder. The request is for physical therapy 2 times a week for 6 weeks, left shoulder. There is no RFA provided and the patient's date of injury is 12/23/11. The diagnoses include shoulder pain, left rotator cuff syndrome and tenosynovitis, bicipital (left). Per 03/31/15 report, physical examination revealed no AC joint tenderness with mild bicipital groove tenderness and mild lateral acromion tenderness. There is positive Obrian's test and negative for Hawkin's, Neer's, and cross-body testing. Per 03/16/15 report, MRI of the left shoulder performed on 07/01/13, revealed moderate extensive tendinopathy and fraying or partial tearing of the supraspinatus tendon with near complete full thickness rotator cuff tear at the humeral attachment and degenerative joint disease and capsular hypertrophy of the left acromioclavicular joint with calcific tendinosis at the infraspinatus tendon. The patient ambulates with a wheeled walker and has a slowed gait. Prior treatments included physical therapy, heat and medications. Current medications include Tramadol, Nasonex, low dose Aspirin, Lantus and Humalog and medical marijuana. The patient is temporarily totally disabled. MTUS pages 98, 99 has the following: "Physical Medicine: recommended as indicated below. Allow for fading of treatment frequency from up to 3 visits per week to 1 or less, plus active self-directed home Physical Medicine." MTUS guidelines pages 98, 99 states that for "Myalgia and myositis, 9-10 visits are recommended over 8 weeks. For Neuralgia, neuritis, and radiculitis, 8-10 visits are recommended." MTUS post-surgical guidelines, pages 26-27, recommend 24 visits over a period of 14 weeks. The post-operative time frame is 6 months. Per 03/31/15 report treater states, "Patient elected to proceed with physical therapy. Physical therapy has been prescribed..." Given the patient's diagnosis, continued symptoms, a short course of physical therapy would be indicated by guidelines. The UR dated 04/09/15 states the patient has completed 14 sessions of physical therapy to date. In this case, treater does not discuss any flare-ups, does not explain why on-going therapy is needed, nor reason why patient is unable to transition into a home exercise program. Furthermore, the request for an additional 12 sessions would exceed what is allowed by MTUS. Therefore, the request IS NOT medically necessary.