

Case Number:	CM13-0022270		
Date Assigned:	11/13/2013	Date of Injury:	02/23/2010
Decision Date:	01/28/2014	UR Denial Date:	08/15/2013
Priority:	Standard	Application Received:	09/09/2013

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Family Practice and is licensed to practice in Texas. 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 physician 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 40-year-old female who presents status post a work-related injury sustained on 02/23/2010 as result of strain to the right shoulder and the cervical spine. The patient is subsequently status post right shoulder arthroscopic debridement, tenosynovectomy, bursectomy, ligament release, rotator cuff debridement, and manipulation under anesthesia as of 06/21/2013 under the care of [REDACTED]. The most recent clinical note submitted for review was dated 10/08/2013. The clinical note reports the patient was seen under the care of [REDACTED] for her continued pain complaints. The provider documents in addition to shoulder surgery, the patient is status post a right wrist carpal tunnel release as of 03/23/2012. The patient utilizes Flexeril, omeprazole, tramadol, and topical analgesics for her pain complaints. The provider documented upon physical exam of the cervical spine, the patient's range of motion was limited and painful upon flexion and extension on the right; however, the provider documented the values of range of motion were within normal limits. The provider documented the patient's bilateral shoulder range of motion values were within normal limits on the left, 170 degrees flexion, 46 degrees extension, 170 degrees abduction, 50 degrees adduction, 80 degrees internal rotation, 80 degrees external rotation to the right. The provider documented the patient had 5/5 motor strength throughout the bilateral upper extremities.

IMR ISSUES, DECISIONS AND RATIONALES

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

Six (6) physical therapy visits over 4 weeks: Upheld

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

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

Decision rationale: The Physician Reviewer's decision rationale: The current request is not supported. The clinical documentation submitted for review lacks evidence to support supervised therapeutic interventions for this patient at this point in her treatment. The clinical notes lacked evidence of the patient's reports of efficacy with previous postoperative physical therapy; duration or frequency of completion of therapeutic sessions. In addition, the most recent clinical notes submitted for review failed to evidence significant objective findings of symptomatology; the patient had full range of motion of the cervical spine and near full range of motion to the right shoulder and full range of motion to the left shoulder. Given the lack of documentation of significant objective findings of symptomatology and reports of efficacy with the previous physical therapy interventions, as well as the current request does not specify for what bodily injury the 6 sessions of physical therapy are to be utilized for, the request for 6 physical therapy visits over 4 weeks is not medically necessary or appropriate.

Post-op additional physical therapy 3 x 4 weeks, on right shoulder: Upheld

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

MAXIMUS guideline: Decision based on MTUS Postsurgical Treatment Guidelines Page(s): 27.

Decision rationale: The Physician Reviewer's decision rationale: The current request is not supported. The clinical documentation submitted for review lacks evidence to support supervised therapeutic interventions for this patient at this point in her treatment. The clinical notes lacked evidence of the patient's reports of efficacy with previous postoperative physical therapy; duration or frequency of completion of therapeutic sessions. In addition, the most recent clinical notes submitted for review failed to evidence significant objective findings of symptomatology; the patient had full range of motion of the cervical spine and near full range of motion to the right shoulder and full range of motion to the left shoulder. California MTUS, Postsurgical Treatment Guidelines support 24 sessions of physical therapy over 14 weeks postoperatively for the patient's shoulder surgery performed in 06/2014. Given the lack of documentation evidencing the patient's course of postoperative treatment and the efficacy of treatment, as well as lack of significant objective findings of symptomatology upon exam of the patient, the request for post-op additional physical therapy 3 x 4 weeks, right shoulder is not medically necessary or appropriate.