

Case Number:	CM13-0031537		
Date Assigned:	12/11/2013	Date of Injury:	02/18/2012
Decision Date:	02/19/2014	UR Denial Date:	09/23/2013
Priority:	Standard	Application Received:	10/03/2013

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 Orthopedic Surgery and is licensed to practice in Louisiana and 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 48-year-old male who reported a work-related injury on 02/18/2012; the specific mechanism of injury was noted as a strain to the right shoulder. The patient is subsequently status post a right shoulder arthroscopy, superior labral anterior posterior debridement, rotator cuff repair, subacromial decompression and bursectomy and acromioplasty as of 02/25/2013. The clinical note dated 06/24/2013 reported that the patient was seen under the care of [REDACTED]. The provider documented that the patient continued with residual symptomatology to the right shoulder. The provider administered an injection to the shoulder on a previous visit, which afforded the patient 1 week of pain relief. Upon exam of the right shoulder, the provider documented that there was a fair amount of limited motion. There was tenderness around the shoulder girdle and subacromial space laterally. There was some discomfort and tenderness over the top of the acromioclavicular joint. Internal rotation and forward flexion reproduced the patient's symptomatology. Rotator cuff function appeared to be intact; however, pain was elicited. The provider documented that the patient could continue working modified duties with no use of the right shoulder.

IMR ISSUES, DECISIONS AND RATIONALES

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

Physical therapy 2 x week x 4 weeks for right shoulder: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

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

Decision rationale: The current request is not supported. The clinical notes document that the patient was status post right shoulder surgical interventions as of 02/2013. However, documentation of any postoperative course of physical therapy interventions, including duration, frequency and efficacy of treatment, was not included in the clinical notes reviewed. At this point in the patient's treatment, further supervised therapeutic interventions cannot be supported. The California MTUS indicates to allow for a fading of treatment frequency from up to 3 visits per week to 1 or less plus active, self-directed home physical medicine. Given all of the above, the request for physical therapy 2 times a week times 4 weeks for the right shoulder is neither medically necessary nor appropriate.