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| <b>Case Number:</b>   | CM13-0048893 |                              |            |
| <b>Date Assigned:</b> | 12/27/2013   | <b>Date of Injury:</b>       | 09/15/2010 |
| <b>Decision Date:</b> | 02/26/2014   | <b>UR Denial Date:</b>       | 10/18/2013 |
| <b>Priority:</b>      | Standard     | <b>Application Received:</b> | 11/06/2013 |

### 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 Physical Medicine & Rehabilitation and is licensed to practice in New York 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 63-year-old female who reported an injury on 09/15/2010 due to holding a ladder that fell and hit her forehead; which caused injury to her head, right knee, and right shoulder. The patient ultimately underwent right shoulder arthroscopy with labral debridement and subacromial decompression. The patient's most recent clinical evaluation did not include any right shoulder deficits that would require any kind of medication management. The patient's most recent exceptional factors in the lower extremity did reveal popliteal tenderness. However, the patient had a negative Homan's sign and Lisker's sign. The patient's diagnoses included pre-existing right shoulder injury with prior right shoulder, status post left shoulder rotator cuff repair, and possible DVT of the left leg in the popliteal region. The patient's treatment plan included physical therapy of the right shoulder and a venous Doppler of the left lower extremity to rule out a deep vein thrombosis.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Venous Doppler for the left lower extremity:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG).

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG, Knee & Leg Chapter, Venous Thrombosis.

**Decision rationale:** The requested outpatient venous Doppler for the left lower extremity is not medically necessary or appropriate. The clinical documentation submitted for review does provide evidence that the patient has popliteal tenderness. Official Disability Guidelines do recommend venous Doppler to assist in determining whether a patient has a thromboembolism or not. However, the clinical documentation does not support that the patient is at risk for development of a deep vein thrombosis. The patient had negative physical symptoms for a deep vein thrombosis to include a negative Homan's sign and a negative Lisker's sign. Therefore, the need for this diagnostic studies is not supported. As such, the outpatient venous Doppler for the left lower extremity is not medically necessary or appropriate.

**Physical therapy for the right shoulder (6 sessions):** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Page(s): 98-99.

**Decision rationale:** The requested physical therapy for the right shoulder is not medically necessary or appropriate. California Medical Treatment Utilization Schedule states active therapy is based on the philosophy that therapeutic exercise and/or activity are beneficial for restoring flexibility, strength, endurance, function, range of motion, and can alleviate discomfort. The clinical documentation submitted for review does not provide any evidence of deficits of the right shoulder that would require physical therapy. The patient does not have any complaints of the right shoulder, weakness, or limited range of motion. Therefore, the need for physical therapy is not clearly identified. As such, the requested physical therapy for the right shoulder, 2 times a week for 3 weeks is not medically necessary or appropriate.