

Case Number:	CM14-0000714		
Date Assigned:	01/17/2014	Date of Injury:	04/12/2012
Decision Date:	04/30/2014	UR Denial Date:	12/24/2013
Priority:	Standard	Application Received:	01/02/2014

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 Occupational Medicine, and is licensed to practice in California. 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 an employee of [REDACTED] and has submitted a claim for osteoarthritis, left shoulder associated with an industrial injury date of 04/12/2012. Treatment to date has included reverse total left shoulder replacement on 04/19/2013, physical therapy, steroid injections, oral and topical medications. Utilization review from 12/24/2013 modified the request for physical therapy left shoulder 3 x 6 into physical therapy left shoulder 2 x 6 instead. The reason for modification was not disclosed in the submitted records. Medical records from 2012 to 2013 were reviewed showing that patient has been experiencing chronic and constant left shoulder pain graded 5-6/10. Overhead exercises to the left shoulder aggravate the pain. Physical examination showed weakness of the left wrist extensor and biceps at 4/5. Left shoulder range of motion was decreased with forward flexion at 80 degrees, abduction at 70 degrees, internal rotation at 30 degrees and external rotation at 45 degrees. Current medications include Soma (carisoprodol) 350mg tablet, 1 tablet BID prn for spasm, Norco (hydrocodone/APAP) 10/325mg tablet, 1 tablet every 4-6 hours prn for pain, Ultracet (tramadol/APAP) 37.5/325mg tablet every 4-6 hours prn for pain, Methoderm gel 120gm and Flurbiprofen 20% gel 120 gm, apply BID-TID.

IMR ISSUES, DECISIONS AND RATIONALES

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

PHYSICAL THERAPY FOR THE LEFT SHOULDER, THREE (3) TIMES A WEEK FOR SIX (6) WEEKS: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Page(s): 98-99. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Section Shoulder, Physical Therapy

Decision rationale: The MTUS Postsurgical Treatment Guidelines support 24 physical therapy visits following shoulder arthroplasty for osteoarthritis. In this case, the employee has completed 10 physical therapy sessions to the left shoulder from 6/28/2013 to 9/27/2013. As stated on pages 98-99 of the MTUS Chronic Pain Medical Treatment Guidelines, physical medicine is recommended and that given frequency should be tapered and transition into a self-directed home program. The present request will have a total of additional 18 therapy sessions that would exceed guideline recommendations. Furthermore, the frequency of the request does not follow the recommended tapering of visits to allow transition into an independent home exercise program. Therefore, the request for physical therapy for the left shoulder, three (3) times a week for six (6) weeks is not medically necessary and appropriate.