

Case Number:	CM14-0002041		
Date Assigned:	01/31/2014	Date of Injury:	01/18/2013
Decision Date:	08/11/2014	UR Denial Date:	12/23/2013
Priority:	Standard	Application Received:	01/07/2014

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. The expert reviewer is Board Certified in Physical Medicine and Rehabilitation 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 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/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 injured worker is a 59-year-old female who reported an injury on 01/18/2013. The mechanism of injury was noted to be repetitive work. Prior treatments included medication and physical therapy. The injured worker's diagnosis was noted to be left shoulder pain status post left shoulder arthroscopy/rotator cuff repair on 05/22/2014. The injured worker had a postoperative visit on 05/29/2014. She reported pain was under control. The physical examination revealed incisions were healing well, and the neurovascular region was intact. The treatment plan included a sling for 2 months and physical therapy. The provider's rationale for the request was provided within the postoperative visit on 05/29/2014. A Request for Authorization for Medical Treatment was not provided within the review.

IMR ISSUES, DECISIONS AND RATIONALES

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

PHYSICAL THERAPY LEFT SHOULDER 2X3 WEEKS: Upheld

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

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

Decision rationale: The request for physical therapy left shoulder 2x3 weeks is not medically necessary. It is noted within the documentation provided that the injured worker had rotator cuff repair/acromioplasty on 05/22/2014. A postoperative evaluation on 05/29/2014 indicates an order for physical therapy. A utilization review document notes postoperative physical therapy was certified for 12 visits. The California MTUS postsurgical treatment guidelines recommend an initial course of therapy 1 half of the number of visits specified in the general course of therapy for the specific surgery in the postsurgical physical medicine treatment recommendation. The postsurgical treatment recommendation for a rotator cuff repair/acromioplasty is 24 visits over 14 weeks with a postsurgical physical medicine treatment period of 6 months. The documentation does not provide the total number of visits the injured worker has used postoperatively to date. The last clinical note provided postoperatively does not document a pain rating, functional deficits, decreased range of motion or decreased motor strength. In addition, the request fails to note the number of visits requested. Therefore, the request for physical therapy left shoulder 2x3 weeks is not medically necessary.