

| | | | |
|-----------------------|--------------|------------------------------|------------|
| Case Number: | CM14-0002649 | | |
| Date Assigned: | 01/31/2014 | Date of Injury: | 03/07/2005 |
| Decision Date: | 06/19/2014 | UR Denial Date: | 12/20/2013 |
| Priority: | Standard | Application Received: | 01/08/2014 |

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 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 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 52-year-old female who sustained an injury to her right shoulder on March 7, 2005. The mechanism of injury was not documented. A clinical note dated June 3, 2013 reported the injured worker had returned to the clinic for preoperative evaluation regarding her right shoulder. The injured worker had undergone two previous surgeries to address the right shoulder. The injured worker was scheduled for right shoulder diagnostic and operative arthroscopic with rotator cuff repair dated July 26, 2013. The injured worker continued to have weakness and pain in her right shoulder. The injured worker was considered totally and temporarily disabled. She was recommended to continue ice, anti-inflammatories, self-directed stretching and strengthening exercises over the next six weeks.

IMR ISSUES, DECISIONS AND RATIONALES

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

PHYSICAL THERAPY FOR THE RIGHT SHOULDER, 2X6 WEEKS: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation MTUS: AMERICAN COLLEGE OF OCCUPATIONAL AND ENVIRONMENTAL MEDICINE PRACTICE GUIDELINES, 2ND EDITION, 2004, CHAPTER 9 (SHOULDER COMPLAINTS), as well as the Post Surgical Treatment Guidelines.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation MTUS: CHRONIC PAIN MEDICAL TREATMENT GUIDELINES , ROTATOR CUFF SYNDROME/IMPINGEMENT SYNDROME, page 27.

Decision rationale: The request for physical therapy two times a week times six weeks for the right shoulder is not medically necessary. The previous request was denied on the basis that the records submitted indicated that the injured worker has had at least twelve physical therapy visits certified; however, the total number completed and response to conservative care was not clear, as there were no physical therapy notes submitted for review. Further, it was noted that the injured worker sustained limited benefit with previous postoperative physical therapy. There was no additional significant objective clinical information provided for review that with support continued physical therapy. Given the clinical documentation submitted for review, medical necessity of the request for physical therapy two times a week times six weeks for the right shoulder has not been established. The request for physical therapy for the right shoulder, twice per week for six weeks, is not medically necessary or appropriate.