

Case Number:	CM14-0007911		
Date Assigned:	02/07/2014	Date of Injury:	12/12/2012
Decision Date:	06/23/2014	UR Denial Date:	12/26/2013
Priority:	Standard	Application Received:	01/17/2014

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 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 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 patient is a 29-year-old male who has submitted a claim for right shoulder strain, partial rotator cuff and superior labral anterior to posterior tear status post right shoulder diagnostic and operative arthroscopy with anterior capsulolabral repair, Bankart procedure on April 19, 2013 associated with an industrial injury date of December 12, 2012. The patient has been experiencing right shoulder pain which he graded as moderate to severe. The shoulder pain radiates down into his biceps towards the back of his arm and at times up towards his neck. It was aggravated by activities at and above shoulder level. There was also a popping, clicking and grinding sensation noted when lifting his arm upward or out to the side and across his body. Physical examination of the right shoulder showed discomfort with deep palpation on the acromioclavicular joint. Impingement sign is negative and there is no evidence of anterior, posterior or inferior instability. Muscle testing is 4/5 on the right shoulder with intact sensation. MRI of the right shoulder, dated January 7, 2013, revealed low grade articular sided partial thickness tearing of the supraspinatus tendon adjacent to the footprint, mild tendinosis infraspinatus and subscapularis tendons, tearing of the superior/anterosuperior labrum and mild acromioclavicular joint osteoarthritis. Treatment to date has included medications, steroid injections, physical therapy and surgery. Utilization review, dated February 5, 2014, modified the request for physical therapy 2 times a week for 6 weeks to the right shoulder to physical therapy 2 times a week for 2 weeks to the right shoulder to address the remaining deficits, improve the claimant's overall function and transition to home exercise program for self-management thereafter. In addition, utilization review last December 26, 2013, denied the request for physical therapy 2 times a week for 6 weeks for the right shoulder since the patient has already exceeded the recommended physical therapy sessions and denied the request for

massage therapy 2 times a week for 6 weeks for the right shoulder because it is not clear if the patient has been compliant with a home exercise program.

IMR ISSUES, DECISIONS AND RATIONALES

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

PHYSICAL THERAPY TWO TIMES A WEEK FOR SIX WEEKS, RIGHT SHOULDER: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 98-99.

MAXIMUS guideline: Decision based on MTUS Postsurgical Treatment Guidelines.

Decision rationale: The California MTUS Post-Surgical Guidelines indicate that physical medicine treatment period following rotator cuff surgery is 24 visits over 14. In this case, patient underwent right shoulder diagnostic and operative arthroscopy with anterior capsulolabral repair, Bankart procedure last April 19, 2013. A progress report dated December 2, 2013; indicate that the patient's shoulder pain has increased due to the inconsistency of his post-operative right shoulder physical therapy. The patient has completed post-operative physical therapy sessions but information about the treatments were not documented. There was no record regarding the number of physical therapy sessions completed by the patient. Moreover, there is no clear documentation concerning functional gains. There is insufficient evidence or objective findings to prove the necessity for additional physical therapy for the right shoulder. Moreover, the patient should be well versed in a self-directed home exercise program by now. Therefore, the request for physical therapy 2 times a week for 6 weeks, right shoulder is not medically necessary.

MASSAGE THERAPY TWO TIMES A WEEK FOR SIX WEEKS, RIGHT SHOULDER: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 60.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 60.

Decision rationale: The Chronic Pain Medical Treatment Guidelines states that massage therapy is recommended as an adjunct to other recommended treatment and is limited to 4-6 visits. In this case, the reason for requesting massage therapy of the right shoulder was not mentioned in the medical records. In addition, it is unclear if he currently has a home exercise program, a required adjunct to massage therapy. There are no indications in the documentation that the patient is participating in a home exercise program or any other therapy. Therefore, the request for massage therapy two times a week for six weeks, right shoulder is not medically necessary.

