

Case Number:	CM14-0019321		
Date Assigned:	04/21/2014	Date of Injury:	07/15/2009
Decision Date:	07/02/2014	UR Denial Date:	02/03/2014
Priority:	Standard	Application Received:	02/14/2014

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 Orthopedic Surgery, 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 62-year-old who reported an injury to his left shoulder following a work related incident on July 15, 2009. The clinical note dated July 24, 2013 indicates the injured worker having undergone an operative procedure at the left shoulder to include an arthroscopic subacromial decompression as well as a partial rotator cuff repair. The note indicates the injured worker presenting for an eight day postoperative follow up. The injured worker did continue with complaints of neck and shoulder pain. Upon exam, tenderness was identified at the left shoulder with range of motion limitations. The note indicates the injured worker utilizing Norco for pain relief. The therapy report dated January 23, 2014 indicates the injured worker continuing with strength deficits throughout the entire rotator cuff that were rated as 4+/5. The injured worker was able to demonstrate 120 degrees of left shoulder flexion, 120 degrees of abduction, 30 degrees of external rotation, and 60 degrees of internal rotation. The note indicates the injured worker having undergone a course of postoperative therapy following the surgical procedure. The operative report dated July 31, 2013 indicates the injured worker undergoing an examination under anesthesia at the left shoulder as well as an arthroscopic debridement of the partial articular sided tendon evulsion, resection of a torn superior labrum, and extensive debridement of the superior labrum. The injured worker also underwent a Mumford procedure as well as an arthroscopic biceps tenodesis. The previous review resulted in a denial for additional physical therapy as no information was submitted confirming the injured worker's number of postoperative sessions that had been completed.

IMR ISSUES, DECISIONS AND RATIONALES

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

ADDITIONAL POST-OP PHYSICAL THERAPY 2 TIMES A WEEK FOR 6 WEEKS FOR THE LEFT SHOULDER: Upheld

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

MAXIMUS guideline: Decision based on MTUS Postsurgical Treatment Guidelines Page(s): 26.

Decision rationale: The documentation indicates the injured worker complaining of ongoing left shoulder pain despite the previous surgical intervention. There is an indication that the injured worker continued with left shoulder pain. However, no information was submitted regarding the injured worker's functional improvements through the initial course of treatment. Additionally, no information was submitted regarding the number of sessions the injured worker had completed. Therefore, it is unclear if the injured worker would benefit from additional treatment as the submitted information is incomplete. The request for additional post-op physical therapy for the right shoulder, two times weekly for six weeks, is not medically necessary or appropriate.

PHYSICAL THERAPY 2 TIMES A WEEK FOR 6 WEEKS FOR THE RIGHT SHOULDER: Upheld

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

MAXIMUS guideline: Decision based on MTUS Acupuncture Treatment Guidelines, Chronic Pain Treatment Guidelines SHOULDER, IMPINGEMENT Page(s): 26.

Decision rationale: The documentation indicates the injured worker complaining of ongoing left shoulder pain despite the previous surgical intervention. There is an indication that the injured worker continued with left shoulder pain. However, no information was submitted regarding the injured worker's functional improvements through the initial course of treatment. Additionally, no information was submitted regarding the number of sessions the injured worker had completed. Therefore, it is unclear if the injured worker would benefit from additional treatment as the submitted information is incomplete. The request for physical therapy for the right shoulder, two times weekly for six weeks, is not medically necessary or appropriate.