

Case Number:	CM14-0019847		
Date Assigned:	04/28/2014	Date of Injury:	06/08/2009
Decision Date:	07/08/2014	UR Denial Date:	02/04/2014
Priority:	Standard	Application Received:	02/18/2014

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 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 records reviewed note the date of injury as June 8, 2009 for this 54-year-old individual. The mechanism of injury is noted as a lifting event. It is also noted that a number of sessions of physical therapy for the left shoulder had been certified in the preauthorization process as well as an injection involving the right shoulder. There is no evidence of fracture, acromioclavicular glenohumeral osteoarthritis directly imaging studies completed at the time of injury. The rotator cuff tear of the right shoulder was identified and ultimately treated with surgical intervention. MRI of the left shoulder noted a severe tendinosis of the supraspinatus. A full thickness tear was reported in June, 2012. A repeat MRI of the left shoulder was obtained in June, 2013 and the changes on only rotator cuff repair are identified. A repeat full thickness tear of the supraspinatus is also noted. The orthopedic consultation completed on May 1, 2013 noted left shoulder pain, weakness to both shoulders, and stiffness along both shoulders. The physical examination noted a marked decrease in shoulder range of motion and right shoulder strength was slightly reduced. The clinical assessment was a rotator cuff tendinosis and chronic partial posterior subluxation of the right shoulder as well as adhesive capsulitis. The repeat right shoulder surgery was completed in October, 2012. They July 15, 2013 progress note indicates an increased loss of shoulder range of motion bilaterally. An Agreed Medical Reevaluation completed in September, 2013 noted that maximum medical improvement had not been reached. Treatment to this date was outlined. The physical examination noted this 5'4", 170 pound individual to have complaints of neck pain with a decrease in active range of motion, well healed surgical scars in the bilateral shoulders, and rather full activity and passive shoulder range of motion. A decrease in motor function/strength is also reported. Additional physical therapy for the shoulder was suggested. Certification of the right shoulder injection was made in November, 2013. The December 2013 follow-up progress note is identical to the previously notes.

IMR ISSUES, DECISIONS AND RATIONALES

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

12 SESSIONS OF PHYSICAL THERAPY: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 98.

Decision rationale: Subsequent to the reevaluation completed in the AMD process, a request for physical therapy for the shoulder had been made and certified. The subsequent progress notes do not indicate if this physical therapy had been completed and to what benefit. Therefore, there is insufficient clinical information presented to suggest that additional certification of 12 sessions of physical therapy without notation of the efficacy of the previously endorsed procedure. The request is not medically necessary.

RIGHT SHOULDER INJECTIONS: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 204.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 204.

Decision rationale: It is noted that this request was certified in the preauthorization process in November, 2013. There are no progress notes indicating the efficacy or utility of such a injection. As such, a repeat injection would not be supported. There is insufficient clinical data to support this request. A repeat reconsideration for this request is not certified in December again as there was no noted efficacy or utility of the injection. The request is not medically necessary.

MRI OF THE LEFT SHOULDER: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 207-208.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 207.

Decision rationale: Two separate MRIs of the left shoulder, as well as a surgical intervention, have been noted. Multiple orthopedic consultation relative to the shoulder have been completed and it is reported that there is tenderness, decreased range of motion and decreased motor function. Subsequent to the last MRI, completed after surgical intervention and noting a tear had reoccurred, there is no noted integral event to suggest any additional pathology. Therefore, there

is insufficient clinical information presented to support this request and thus it is not medically necessary.