

Case Number:	CM14-0150940		
Date Assigned:	09/19/2014	Date of Injury:	08/09/2001
Decision Date:	10/20/2014	UR Denial Date:	09/08/2014
Priority:	Standard	Application Received:	09/16/2014

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, has a subspecialty in Interventional 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 53 year old male with an injury date of 08/09/01. The 06/20/14 report by [REDACTED] states the patient presents with right hip pain radiating to right testicle rated 4-5/10 and shoulder pain rated 5-6/10 to 10/10 that radiates to the arm, forearm, hand and upper right thoracic area. No objective examination was provided on this report. The patient is noted to be post Arthroscopic labral debridement (May 2013). The patient's diagnoses include: 1. Hip pain due to failed right hip revision secondary to socket loosening s/p revision 1/24/12, 2. Medial meniscus tear left knee, 3. Shoulder pain, s/p repair of rotator cuff and labral tears. The utilization review being challenged is dated 09/08/14. Treatment reports are provided from 05/12/14 to 06/20/14.

IMR ISSUES, DECISIONS AND RATIONALES

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

PT x 16 visits right shoulder: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints, Chronic Pain Treatment Guidelines.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Page(s): 98, 99.

Decision rationale: The patient presents with right hip pain rated 4-5/10, shoulder pain rated 5-10/10 radiating to the arm, forearm, hand and upper right thoracic area. The treater requests for Physical therapy x 16 visits for right shoulder. The patient is status post Arthroscopic labral debridement of the shoulder (May 2013). The 05/12/14 treatment plan recommends Physical therapy to decrease pain and inflammation for the right shoulder. The report notes suspected soft tissue pathology with complications associated with neck pain and radicular "sx". The patient is to transition to resistance training, PROM/AAROM and an independent home exercise program. The only physical therapy report provided appears to show treatment for the right knee. The patient is outside the treatment period for post-surgical physical therapy. The treater does note that right shoulder pain began 01/15/14 while at home. , MTUS pages 98,99 states that for Myalgia and myositis 9-10 visits are recommended over 8 weeks. For Neuralgia, neuritis and radiculitis 8-10 visits are recommended. While the patient may benefit from a course of physical therapy for his shoulder, the 16 visits requests exceed what is allowed by MTUS. Therefore, recommendation is for denial.