

Case Number:	CM14-0021969		
Date Assigned:	04/14/2014	Date of Injury:	09/15/2008
Decision Date:	05/15/2014	UR Denial Date:	02/13/2014
Priority:	Standard	Application Received:	02/21/2014

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician 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 physician 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 62-year-old claimant is status postindustrial injury to left shoulder on 9/15/08. The diagnosis is traumatic arthropathy of the shoulder. Left shoulder CT arthrogram on 3/29/12 demonstrates no loosening of left proximal prosthesis and no contrast extravasation into the subacromial/subdeltoid bursae. Left subscapularis tendon appeared intact without any tear identified. Exam note 5/20/13 demonstrates complaint of left shoulder pain. Report of acromioclavicular injection performed into the left shoulder with good relief of pain. Exam note 1/13/14 demonstrates request for revision left shoulder rotator cuff repair. Exam demonstrates 4/5 supraspinatus abduction with lift off and Belly tests abnormal

IMR ISSUES, DECISIONS AND RATIONALES

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

12 POST OP PHYSICAL THERAPY VISITS FOR THE LEFT SHOULDER (ROTATOR CUFF REPAIR): Upheld

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

MAXIMUS guideline: The Expert Reviewer did not cite any medical evidence for its decision.

Decision rationale: Since the primary procedure is not medically necessary, none of the associated services are medically necessary