

Case Number:	CM14-0055145		
Date Assigned:	07/07/2014	Date of Injury:	09/12/2013
Decision Date:	08/07/2014	UR Denial Date:	04/15/2014
Priority:	Standard	Application Received:	04/24/2014

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:

This 45-year-old male sustained an industrial injury on 9/12/13. Injury occurred while lifting a table and twisting. The mechanism of injury was not documented. The patient was status post right shoulder arthroscopic rotator cuff repair, debridement of glenoid labral tear, acromioplasty, and distal clavicle resection on 10/30/13. Records indicated that the patient initiated physical therapy on 1/3/14. The 3/17/14 orthopedic surgeon report cited grade 7/10 right shoulder pain in flexion and pain worse with motion. Range of motion testing was not performed as the patient was in too much pain to take off his brace. Stability was reported normal. The patient was unable to perform grip testing with the right hand. Additional physical therapy was requested with a registered physical therapist for active and passive range of motion. The 4/15/14 utilization review denied the request for additional physical therapy, as there was no objective benefit documented with physical therapy to date and no indication why he was unable to continue his rehabilitation with a home exercise program. The 4/30/14 orthopedic report cited the patient was status post right shoulder surgery with residual 8/10 pain and decreased range of motion. Right shoulder range of motion testing documented flexion 100, abduction 80, external rotation 50, internal rotation 70, and adduction/extension 40. There was 4/5 strength in all directions. There was positive subacromial bursitis and improvement tests. Drop arm, Speed's, and O'Brien's tests were negative. There were no signs of instability within the achievable range of motion. There was a trapezius muscle spasm. X-rays of the right shoulder revealed mild to moderate acromioclavicular joint degenerative joint disease. The diagnosis was status post right shoulder surgical intervention with residual adhesive capsulitis, bursitis, and impingement. Additional physical medicine treatment was recommended.

IMR ISSUES, DECISIONS AND RATIONALES

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

Additional Physiotherapy, 2 x per week for 6 weeks, to the Right Shoulder: Overturned

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

MAXIMUS guideline: Decision based on MTUS Postsurgical Treatment Guidelines Page(s): 27.

Decision rationale: The California MTUS Post-Surgical Treatment Guidelines for rotator cuff repair/acromioplasty suggest a general course of 24 post-operative visits over 14 weeks during the 6-month post-surgical treatment period. If it is determined additional functional improvement can be accomplished after completion of the general course of therapy, physical medicine treatment may be continued up to the end of the postsurgical physical medicine period. The post-surgical period would have continued until 4/30/14. The MTUS Chronic Pain Medical Treatment Guidelines would apply after 4/30/14. The MTUS guidelines recommend therapies focused on the goal of functional restoration rather than merely the elimination of pain. The physical therapy guidelines state that patients are expected to continue active therapies at home as an extension of treatment and to maintain improvement. Guideline criteria have been met. This patient appears to have attended a course of physical therapy with significant residual limitation in range of motion and continued global shoulder weakness. Additional physical therapy would be supported to address the functional limitations documented and fully mature a home exercise program. Therefore, this request for additional physiotherapy, two x per week for 6 weeks, to the right shoulder is medically necessary.