MAXIMUS Federal Services

Case Number:	CM14-0060673		
Date Assigned:	07/09/2014	Date of Injury:	08/17/2011
Decision Date:	08/22/2014	UR Denial Date:	04/15/2014
Priority:	Standard	Application Received:	05/01/2014

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 44-year-old female sustained an industrial injury on 8/17/11, relative to a motor vehicle accident. The patient underwent right shoulder arthroscopic glenohumeral capsular release, extensive glenohumeral debridement and synovectomy, subacromial decompression, and manipulation under anesthesia on 10/3/13. The 1/13/14 physical therapy progress report indicated that 31 post-operative visits had been completed. There was very minimal objective functional improvement documented from 12/2/13 to 1/13/14. Right shoulder range of motion was functional with 4 to 4+/5 global shoulder strength. The patient was compliant in her home exercise program. The 4/4/14 treating physician progress report cited right shoulder discomfort. Difficulty was reported with lifting, pushing, pulling, and reaching. Right shoulder physical exam documented decreased range of motion, 4-/5 strength, and positive impingement sign. The diagnosis was rotator cuff syndrome. Additional physical therapy was requested 1x6 for the right shoulder. The 4/15/14 utilization review denied the request for physical therapy based on an absence of documented functional improvement after the most recent physical therapy care.

IMR ISSUES, DECISIONS AND RATIONALES

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

Physical Therapy 1xwk x 6wks for right shoulder Qty: 6: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Guidelines Page(s): 99. Decision based on Non-MTUS Citation Official Disability Guidelines: Shoulder.

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

Decision rationale: California MTUS Post-Surgical Treatment Guidelines do not apply to this case as the 6-month post-surgical treatment period had expired. MTUS Chronic Pain Medical Treatment Guidelines would apply. 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 not been met. There is no clear functional deficit or functional treatment goal to be addressed by additional physical therapy. There was very minimal objective functional change over the most recent course of physical therapy. There is no compelling reason to support additional supervised physical therapy over an independent home exercise program. Therefore, this request for physical therapy 1x6 for the right shoulder is not medically necessary.