

Case Number:	CM14-0068227		
Date Assigned:	07/14/2014	Date of Injury:	12/14/2012
Decision Date:	12/23/2014	UR Denial Date:	04/30/2014
Priority:	Standard	Application Received:	05/13/2014

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 68 year old male was injured at work on 12/14/2012. He complained of left shoulder pain and weakness. MRI report was not available during this review. Past medical history: hypertension, prostate cancer, right and left carpal tunnel release, right and left middle trigger finger release and right first dorsal compartment release. He underwent a left shoulder arthroscopy subacromial decompression with rotator cuff repair surgery on 10/11/2013. Laboratory studies were performed on 09/30/2013. Per documentation the injured worker completed physical therapy; however the numbers of completed sessions are unclear. On treating physicians report dated 02/27/2014 the injured worker was noted to have an increase in range of motion with therapy with forward flexion from previous 0 to 165 degrees, external rotation previous 0 to 35 degrees and internal rotation T12. Documentation states that he is temporary total disabled. Diagnosis was status post left shoulder arthroscopy subacromial decompression with rotator cuff repair. Plan of treatment was additional therapy. The Utilization Review dated 04/30/2014 non-certified Additional Post-Op physical therapy (PT) 2x4 Left Shoulder as not medically necessary. The reviewing physician referred to CA MTUS recommendations.

IMR ISSUES, DECISIONS AND RATIONALES

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

Additional post-op physical therapy 2 x 4 left shoulder: Upheld

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

MAXIMUS guideline: Decision based on MTUS Postsurgical Treatment Guidelines Page(s): 27. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder, Physical therapy, Other Medical Treatment Guideline or Medical Evidence: Postsurgical Treatment Guidelines; and Title 8, California Code of Regulations, section 9792.20

Decision rationale: MTUS Postsurgical Treatment Guidelines identifies up to 24 visits of post-operative physical therapy over 14 weeks and post-surgical physical medicine treatment period of up to 6 months. In addition, MTUS postsurgical treatment Guidelines identifies that the initial course of physical therapy following surgery is 1/2 the number of sessions recommended for the general course of therapy for the specified surgery. MTUS-Definitions identifies that any treatment intervention should not be continued in the absence of functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications or medical services. ODG identifies that when treatment requests exceeds guideline recommendations, the physician must provide a statement of exceptional factors to justify going outside of guideline parameters. Within the medical information available for review, there is documentation of a diagnosis of status post left shoulder arthroscopy subacromial decompression with rotator cuff repair on 10/11/13. In addition, there is documentation of completion of previous postoperative physical therapy sessions. However, given documentation of 40 postoperative physical therapy sessions completed to date, which exceeds guidelines, there is no documentation of remaining functional deficits that would be considered exceptional factors to justify exceeding guidelines. In addition, there is no documentation of functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications or medical services as a result of physical therapy provided to date. Therefore, based on guidelines and a review of the evidence, the request for additional post-op physical therapy 2 x 4 left shoulder is not medically necessary.