

Case Number:	CM14-0083634		
Date Assigned:	07/21/2014	Date of Injury:	05/25/2000
Decision Date:	08/26/2014	UR Denial Date:	05/01/2014
Priority:	Standard	Application Received:	06/05/2014

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 Neuromuscular Medicine and is licensed to practice in Maryland. 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 54 year old male with a work injury dated 5/22/00. The diagnoses include left shoulder adhesive capsulitis and bicipital tendinopathy. Under consideration is a request for physical therapy times 6 left shoulder. There is an orthopedic physician document dated 4/2/14 that states that he is status post rotator cuff repair or surgery on his left and his right sides and has had a herniorrhaphy in the past. He notes that he has had a couple of flares of left shoulder discomfort. His first left shoulder surgery was completed in 1998, and he notes there was fraying of the rotator cuff tendon and repair was completed with some overlap of the tendon. His right-sided surgery was completed in 2000. He also had a rotator cuff tear. He has had a flare of discomfort in his left shoulder. At one point in 2008, he notes that an MRI was completed and an injection completed and this improved his discomfort. He was told that he had a slight tearing of one of the tendons. He notes that about six months ago he had another flare of his left shoulder discomfort to the point where he had difficulty with any sort of motion. He notes that he continues to have some difficulty with motion and pain. The pain has been predominantly in the anterior and lateral anterior aspect of the shoulder. He has some difficulty getting his clothes on and lying on his left side. He did not have any injury that brought this on. X-rays of the left shoulder obtained at this visits revealed evidence of very generous acromioplasty and distal clavicle excision with adequate appearing subacromial space. No evidence of significant glenohumeral osteoarthritis changes. The upper lung fields appear intact on these limited views. No other cortical or trabecular abnormalities are seen. There are no calcific deposits within the tendons. One exam there is no atrophy in either upper extremity. He appears to have decreased range of motion of his left shoulder. He is able to internally rotate to his back pocket only. External rotation is to 20 degrees. Forward elevation is to 120, and he has some breakaway

weakness. There is tenderness directly overlying the head of the biceps tendon along with some impingement signs, although these are difficult to check given his decreased range of motion. Distally he appears to be neurovascularly intact with good range of motion of his elbow, wrist, and digits. The treatment plan included a cortisone injection for his biceps tendonitis as well as a referral to physical therapy (PT).

IMR ISSUES, DECISIONS AND RATIONALES

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

Physical Therapy times 6 Left Shoulder: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Page(s): 98-99.

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

Decision rationale: Physical therapy times 6 for the left shoulder is not medically necessary per the MTUS Chronic Pain Medical Treatment Guidelines. The guidelines state that up to 10 visits are appropriate for this condition. The documentation is not clear on how much past therapy the patient has had or outcome of this therapy. Without this information additional therapy cannot be certified and therefore the request for physical therapy times 6 to left shoulder is not medically necessary.