

Case Number:	CM14-0086078		
Date Assigned:	07/23/2014	Date of Injury:	08/29/2011
Decision Date:	09/22/2014	UR Denial Date:	05/27/2014
Priority:	Standard	Application Received:	06/09/2014

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 Anesthesiology & Pain Medicine and is licensed to practice in Florida. 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 injured worker is a 50-year-old male with a reported injury on 08/29/2011. The mechanism of injury was not provided. The injured worker's diagnoses consisted of right shoulder full thickness rotator cuff tear, right knee medial meniscus tear, significant for early degenerative arthritis, status post open reduction and internal fixation of proximal humerus fracture, status post adhesive capsulitis, a history of brachial plexopathy, left upper extremity unchanged in permanent and stationary status. He also has a diagnosis of unresolved radial nerve palsy, left upper extremity unchanged in permanent stationary status. The injured worker has had previous treatments of multiple physical therapy sessions to multiple parts of his body. He also has had injections. The efficacy of those treatments was not provided. The injured worker had an examination on 04/10/2014 for complaints of ongoing right shoulder pain, right knee pain, and a history of left shoulder injury. Upon examination, they reviewed an MRI of the right shoulder which demonstrated full thickness tear of the supraspinatus, as well as a tear with a 13 mm medial retraction and very minimal fatty infiltration of the supraspinatus fossa. There was also a medial dislocation of the biceps into a superior tear of the suprascapularis with a linear split of the biceps tendon. They also reviewed the study of his MRI of the right knee which demonstrated a tear of the medial meniscus. Upon examination, his right shoulder had 170 degrees of forward flexion, 90 degrees of abduction, scapular stabilization. External rotation was 90 degrees. He did have a positive Neer and Hawkins test. He had 5/5 strength testing. On the examination of his right knee he did have 5 degrees of hyperextension and 140 degrees of flexion. He had a positive McMurray's test medially. A list of medications was not provided. The recommended plan of treatment was for him to have a right shoulder arthroscopic rotator cuff repair and for physical therapy following his surgical procedure. Also, it is recommended for him

to have a corticosteroid injection to his right knee and a short course of physical therapy. The Request for Authorization and the rationale were not provided.

IMR ISSUES, DECISIONS AND RATIONALES

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

Physical Therapy (PT) 3 X 6 to the right shoulder: Upheld

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

MAXIMUS guideline: Decision based on MTUS Postsurgical Treatment Guidelines Page(s): 10 27.

Decision rationale: The MTUS Postsurgical Guidelines recommend that for initial course of therapy following postoperative surgery of the number of visits specified in the general course of therapy. The guidelines recommend postsurgical treatment for arthroscopic rotator cuff syndrome, a total of 24 visits, which half of that would be a total of 12 visits. The request does not specify that this is for postoperative, although on the examination it does state that this is requested for postoperative therapy. The request is asking for 18 sessions, which is over the amount of 12 sessions without further assessment. The clinical information fails to meet the evidence based guidelines for the request. Therefore, the request for the physical therapy 3 x 6 for the right shoulder is not medically necessary.

Physical Therapy (PT) x18 to the right knee: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

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

Decision rationale: The MTUS Chronic Pain Guidelines recommend therapy to be based on the philosophy that therapeutic exercise and activity are beneficial for restoring flexibility, strength, endurance, function, range of motion, and can help alleviate discomfort. Also, the MTUS Chronic Pain Guidelines recommend that patients are instructed and expected to continue active therapies at home as an extension of the treatment process in order to maintain improvement levels. There was a lack of documentation of strength, endurance, function, and flexibility, and a pain assessment to his right knee. There was a lack of evidence of functional deficits. Furthermore, there was no instruction of a home exercise program. Furthermore, the request does not specify frequency and duration of the physical therapy sessions. There is a lack of evidence to support the medical necessity of the physical therapy to the right knee. The clinical information fails to meet the evidence based guidelines for the request. Therefore, the request for the physical therapy to the right knee is not medically necessary and appropriate.

