

Case Number:	CM14-0092109		
Date Assigned:	09/12/2014	Date of Injury:	09/20/2011
Decision Date:	12/09/2014	UR Denial Date:	06/06/2014
Priority:	Standard	Application Received:	06/18/2014

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 Hand Surgery and is licensed to practice in Texas and Georgia. 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 56-year-old male who reported an injury on 09/20/2011 due to an unknown mechanism. Diagnoses were right rotator cuff injury, status post arthroscopy, labral repair, recurrent right shoulder injury, right biceps tendinitis, right shoulder impingement syndrome, SLAP lesion, right shoulder, and cervicobrachial syndrome with cervical disc disease. MRI of the right shoulder, dated 02/27/2014, revealed supraspinatus tendinosis, infraspinatus partial tendon with underlying calcinosis, biceps tenosynovitis, superior labral tear, SLAP type 2 configuration, AC joint osteoarthritis, and osseous cyst of anterolateral humeral head. Physical examination, dated 04/16/2014, revealed that the patient could forward flex the right shoulder to 150 degrees, abduction was to 140 degrees, external rotation was to 70 degrees, and internal rotation was to 30 degrees. Impingement sign was positive and adduction sign was positive. It was reported that the injured worker was troubled by ongoing pain in the shoulder after undergoing a previous surgery. It was reported he had failed extensive nonoperative care. It was recommended that the injured worker undergo surgical treatment. The rationale and Request for Authorization were not submitted.

IMR ISSUES, DECISIONS AND RATIONALES

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

Post-Op Physical Therapy X 12 Visits Right Shoulder: Upheld

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

MAXIMUS guideline: Decision based on MTUS Postsurgical Treatment Guidelines Page(s): 11.

Decision rationale: The decision for post-op physical therapy x 12 visits right shoulder is not medically necessary. The California Medical Treatment Utilization Schedule states if postsurgical physical medicine is medically necessary, an initial course of therapy may be prescribed. With documentation of functional improvement, a subsequent course of therapy shall be prescribed within the parameters of the general course of therapy applicable to the specific surgery. If it is determined that 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 medical guidelines state for rotator cuff syndrome/impingement syndrome postsurgical treatment, arthroscopic is 24 visits over 14 weeks or a treatment period of up to 6 months. Previous conservative care for the injured worker was not reported. Medications for the injured worker were not reported. Also, the most recent clinical note was dated in 04/2014. It is unknown if or when the injured worker is to have surgery. There was no documentation of conservative care failure. The clinical information submitted for review does not provide evidence to justify postop physical therapy x12 visits right shoulder. Therefore, this request is not medically necessary.