

Case Number:	CM14-0096376		
Date Assigned:	09/15/2014	Date of Injury:	03/11/2010
Decision Date:	11/07/2014	UR Denial Date:	06/05/2014
Priority:	Standard	Application Received:	06/19/2014

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 Pain Medicine 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:

The patient is a 49 year old female who was injured on March 11, 2010. The mechanism of injury is unknown. Prior treatment history included NSAIDs, ibuprofen, Tylenol with Codeine, Norco, 9 physical therapy sessions. She underwent left shoulder arthroscopic rotator cuff repair and acromioplasty on January 21, 2014. Initial PT note dated April 4, 2014 documented the patient to have complaints of anterior shoulder pain that is dull in nature and improves with ice. The patient rated the pain as 5/10 at best and 8/10 at worst. On exam, AROM in the left/ right shoulder was as following: flexion 70/180; extension 25/60; abduction 40/175; horizontal abduction 50/40; horizontal adduction 10/40; external and internal rotation 10/90. Strength testing of the upper extremities was 3/5 on the left side and 4/5 on the right side. There was tenderness to palpation of the left bicipital groove/ tendon and supraspinatus tendon. Functional tests were all difficult on the left side and the patient couldn't reach the back of the opposite shoulder. The left shoulder demonstrates hypomobility. PT note dated May 15, 2014 revealed little improvement in the left shoulder flexion and extension ROM to 90 and 70 degrees, respectively. Other findings didn't change. Progress Report dated May 19, 2014 documented the patient complaints of pain in her left shoulder. Physical exam findings included; external rotation to 20 degrees, forward elevation to 90 degrees, and abduction to 45 degrees. The patient was diagnosed with status post left shoulder arthroscopic acromioplasty and rotator cuff repair, and was prescribed Tylenol 3. The physician also recommended physical therapy for the left shoulder once a week for 6 weeks. Prior Utilization Review dated June 5, 2014 denied the request for 6 physical therapy sessions because there is no documented functional improvement from previous sessions.

IMR ISSUES, DECISIONS AND RATIONALES

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

Physical therapy, left shoulder, QTY 6: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Page(s): 98-99. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder, Physical therapy

Decision rationale: CA MTUS 2009 Post-Surgical Treatment Guidelines recommend up to twenty four (24) post-op therapy sessions for this condition. CA MTUS 2009 Chronic Pain Treatment Guidelines recommend continued physical therapy with documented objective evidence of derived functional benefit. It appears the patient has been authorized for twelve (12) postoperative therapy sessions to date. However, there is no documentation of symptomatic or functional improvement from previous therapy sessions. In addition, the authorized physical therapy sessions should have provided time to transition the patient into a dynamic home exercise program to address any ongoing shoulder deficits. Based on the currently available information, the medical necessity for additional therapy has not been established, and therefore, the request is not medically necessary based on guidelines. The request is not medically necessary and appropriate.