MAXIMUS Federal Services

Case Number:	CM14-0146736		
Date Assigned:	09/22/2014	Date of Injury:	08/22/2008
Decision Date:	01/30/2015	UR Denial Date:	08/16/2014
Priority:	Standard	Application Received:	09/10/2014

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:

The injured worker is a 49-year-old female who reported an injury on 08/22/2008. The mechanism of injury occurred while transferring a patient. Her diagnoses included status post right shoulder surgery, lumbar spine sprain/strain, right wrist sprain/strain. Her past treatments have included medications and physical therapy. Her diagnostic studies include an official x-ray of the chest performed on 06/09/2014 read by [redacted] with unremarkable findings. Her surgical history includes a right shoulder arthroscopy with subacromial decompression and debridement performed on 06/19/2014. The injured worker's first physical therapy report dated 07/01/2014 notes the injured worker's right shoulder range of motion values with flexion to 34 degrees, abduction to 28 degrees, external rotation to 17 degrees, and rated her right shoulder pain at 7/10. On 08/18/2014, the injured worker presented with complaints of radiating low back pain to the left lower extremity rated at 8/10 to 9/10, right shoulder pain, bilateral wrist pain; right greater than the left, depression and anxiety. Upon physical examination of the right shoulder, forward flexion upon range of motion was at 100 degrees, abduction was at 100 degrees, extension was at 40 degrees, internal rotation was at 80 degrees, and external rotation was at 70 degrees. Her current medication regimen was not submitted within the documentation. The treatment plan included acupuncture, nerve conduction studies for the upper extremities, a refill of tramadol, Prilosec, Flexeril, Norco, and topical analgesic cream. The treatment plan additionally included a UDS, a continuation of physical therapy, a followup with the shoulder surgeon, a home therapy kit, an order to obtain the AME Report, an order for a psychologist. The rationale for the request was not provided. A Request for Authorization was provided within the submitted documentation, dated 08/18/2014.

IMR ISSUES, DECISIONS AND RATIONALES

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

Continue Post-Operative Physical Therapy quantity: 12.00: Upheld

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

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

Decision rationale: The request to Continue Post-Operative Physical Therapy quantity: 12.00: is not medically necessary. The injured worker has right shoulder pain. The California MTUS Postsurgical Treatment Guidelines recommend 24 visits for an acromioplasty. The documentation submitted for review notes that the injured worker has had postoperative physical therapy for the right shoulder. However, there is no indication of how many number of sessions have been completed. The documentation submitted does show objective functional improvement from physical therapy for the right shoulder and current functional deficits. Additionally, the request as submitted does not indicate which body part the postoperative physical therapy request is for or for what condition. In the absence of the aforementioned documentation, the request as submitted does not support the evidence based guidelines. As such, the request for Continue Post-Operative Physical Therapy quantity:12.00 is not medically necessary.

Range of Motion Measurements quantity:1.00: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 48.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back, Flexibility.

Decision rationale: The request for Range of Motion Measurements quantity: 1.00 is not medically necessary. The injured worker has low back and right shoulder pain. The Official Disability Guidelines do not recommend flexibility as a primary criteria, but should be a part of a routine musculoskeletal evaluation. The relation between lumbar range of motion measures and functional ability is weak or nonexistent. The request as submitted is not supported by the evidence based guidelines. As such, the request for Range of Motion Measurements quantity:1.00 is not medically necessary.