

Case Number:	CM14-0191052		
Date Assigned:	11/24/2014	Date of Injury:	03/30/2013
Decision Date:	01/09/2015	UR Denial Date:	10/27/2014
Priority:	Standard	Application Received:	11/17/2014

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 & Rehabilitation, has a subspecialty in Neuromuscular Medicine and is licensed to practice in New Jersey. 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 55-year-old male who reported injury on 03/30/2013. The mechanism of injury was not provided. Diagnoses included rotator cuff tear of the left shoulder. Past treatments include physical therapy, chiropractic therapy, and medications. On the clinical note dated 09/24/2014, the injured worker complained of constant aching, twisting type and crunching pain in the left shoulder. The injured worker rated his pain a 6/10. Physical examination of the left shoulder indicated range of motion with 70 degrees of flexion and 30 degrees extension, positive impingement sign. Current medications included Tylenol, Lisinopril, and Metformin. The request was for continued physical therapy 2 times 4 left shoulder and MD for medications. The request is for postoperative physical therapy from requested left shoulder arthroscopy, subacromial decompression, and rotator cuff repair. Request for Authorization form was not submitted for review.

IMR ISSUES, DECISIONS AND RATIONALES

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

Continue physical therapy 2 x 4 left shoulder: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical medicine. Decision based on Non-MTUS Citation ODG-TWC: Physical therapy

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

Decision rationale: The request for Continue physical therapy 2 x 4 left shoulder is not medically necessary. The California MTUS Postsurgical Treatment Guidelines state initial course of therapy means 1 half of the number of visits specified in the general course of therapy for the specific surgery in the postsurgical physical medicine treatment recommendations. The guidelines recommend 24 visits over 14 weeks for arthroscopic repair; therefore, an initial course of therapy would be 12 visits. Clinical records indicate the injured worker previously attended physical therapy, and has continued decreased range of motion to the left shoulder. The injured worker was recommended for left shoulder arthroscopy, subacromial decompression and rotator cuff repair for which postoperative physical therapy would be appropriate; however, the medical records lacked documentation indicating the approval of the surgery or that the surgery was completed. Additionally, the medical records lack documentation of number of visits completed, and efficacy of prior therapy. Therefore, the request for Continue physical therapy 2 x 4 left shoulder is not medically necessary.

MD for medications: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG-TWC : Pain chapter

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

Decision rationale: The Official Disability Guidelines recommend office visits to be medically necessary. The guidelines state the need clinical office visit with a healthcare provider is individualized based upon a review of the patient's concerns, signs and symptoms, clinical stability and reasonable physician judgment. The determination is also based on what medications the patient is taking, since some medications such as opioids, or medicines such as certain antibiotics, require close monitoring. There is lack of documentation indicating the patient being prescribed opioids or antibiotics, or medications that would require close monitoring. Therefore, the request for MD for medications is not medically necessary.