

Case Number:	CM14-0198995		
Date Assigned:	12/08/2014	Date of Injury:	12/26/2012
Decision Date:	01/23/2015	UR Denial Date:	11/03/2014
Priority:	Standard	Application Received:	11/25/2014

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 Texas. 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 12/26/2012. The mechanism of injury reportedly occurred when he was driving a clamp lift and the load had fallen down; he reached down with his right shoulder to help pick it up and had immediate pulling and tearing to the right shoulder. A subsequent injury reportedly occurred when he was walking down stairs and had a slip and fall. His diagnoses included right neck and shoulder pain. His past treatments included medications, work modifications, and physical therapy. Diagnostic studies were not provided within the submitted documentation. His surgical history included a right shoulder arthroscopy, acromioplasty, Mumford, and rotator cuff repair on 06/24/2014. The physical therapy progress note dated 10/08/2014 noted the injured worker presented with a decrease in the severity of his right shoulder pain after receiving a cortisone injection. The injured worker further noted that he continued to experience numbness and tingling into his right forearm and digits numbers 1 and 2. He further reported increased activity with household tasks, and rated his pain level a 3/10. Range of motion upon flexion of the right shoulder was limited to 165 degrees, abduction was limited to 160 degrees, external rotation in the neutral position was limited to 75 degrees, and internal rotation was limited to 60 degrees in the neutral position. Motor strength upon flexion was 4/5, upon abduction was 4/5, internal rotation was 4+/5, and external rotation was 4/5. It was further noted that the injured worker had diminished sensation in the right median nerve distribution from right lateral epicondyle to 1st and 2nd digit. His current medications were not provided. The treatment plan included therapeutic exercises, therapeutic activity, manual therapy, and patient education (home exercise program). The rationale for the request was to improve pain relief and decrease inflammation. A Request for Authorization form was not provided within the submitted documentation.

IMR ISSUES, DECISIONS AND RATIONALES

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

12 physical therapy visits: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines, Postsurgical Treatment Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Preface and Shoulder (Acute & Chronic)

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

Decision rationale: The request for 12 physical therapy visits is not medically necessary. The injured worker had right shoulder pain. The clinical note dated 10/08/2014 noted the injured worker demonstrated pain in all directions with active right shoulder range of motion. The progress note further indicated that the injured worker had completed 24 visits postoperative physical therapy sessions for the right shoulder. The California MTUS Postsurgical Treatment Guidelines recommend 24 visits for postsurgical treatment of a sprained shoulder; rotator cuff repair. The clinical notes as submitted did not provide further documentation of current objective functional deficits, or objective functional improvement following previous physical therapy. Additionally, the number of previous therapy visits completed, combined with the number of visits requested, exceeds the number of visits within the guidelines. Moreover, there were no exceptional factors to justify additional supervised visits over a home exercise program. Additionally, the request as submitted did not indicate a body part for the physical therapy request or a frequency of visits. As such, the request as submitted does not support the evidence based guidelines. As such, the request for 12 physical therapy visits is not medically necessary.