

Case Number:	CM15-0001965		
Date Assigned:	01/13/2015	Date of Injury:	01/31/2013
Decision Date:	03/10/2015	UR Denial Date:	12/22/2014
Priority:	Standard	Application Received:	01/05/2015

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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:
 State(s) of Licensure: Pennsylvania
 Certification(s)/Specialty: Internal Medicine

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 59 year old male, who sustained an industrial injury on 01/31/2013 due to a fall. He had reported left upper arm and low back injury. The diagnoses have included full-thickness rotator cuff tear. Treatments to date have included physical therapy and medications. Physical therapy notes were not provided and the dates, duration, and outcome of prior physical therapy was not noted in the documentation submitted. Work status was documented as not at work due to his job not accepting modified duties, temporarily totally disabled. Diagnostics to date have included lumbar spine x-ray which showed anterolisthesis L4 on L5 approximately 3mm and magnetic resonance imaging (MRI) which documented a full-thickness rotator cuff tear; the formal reports were not provided but were discussed in physician progress notes. The progress note of 10/14/14 documents the injured worker complains of left shoulder pain and low back pain. The physician stated the injured worker has failed conservative treatment measures with physical therapy and continues to have weakness, specifically with forward flexion on examination. The physician recommends left shoulder arthroscopic rotator cuff repair with possible subacromial decompression. On 12/22/2014, Utilization Review non-certified the request for postoperative physical therapy two times per week x 3 weeks to the Left Shoulder noting there is no documentation referencing shoulder pain or a rotator cuff tear or prior treatments attempted with the shoulder. The MTUS was cited. On 12/29/2014, the injured worker submitted an application for Independent Medical Review of postoperative physical therapy two times per week x 3 weeks to the Left Shoulder.

IMR ISSUES, DECISIONS AND RATIONALES

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

Post-Operative Physical Therapy twice (2) a week for three (3) weeks to the Left Shoulder:
Overturned

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

MAXIMUS guideline: Decision based on MTUS Postsurgical Treatment Guidelines Page(s): p. 10-12, 26-27.

Decision rationale: The injured worker has a diagnosis of left shoulder rotator cuff tear; the physician documented a plan for left shoulder arthroscopic rotator cuff repair with possible subacromial decompression. This review presumes that a surgery is planned and will proceed. There is no medical necessity for this request if the surgery does not occur. The MTUS states that for complete rupture of the rotator cuff, the post surgical treatment period is 40 visits over 16 weeks, with a post surgical physical medicine treatment period of 6 months. The initial course of therapy representing half the number of visits specified in the general course of therapy for this surgery would be 20 visits. With documentation of functional improvement, a subsequent course of therapy may be prescribed within the parameters of the general course of therapy. The request for authorization notes an order for postoperative physical therapy 2-3 times per week for 6 weeks. The Utilization Review letter and Independent Medical Review request note a request for postoperative physical therapy for two times per week for 3 weeks. These requests are within the amount specified by the guidelines for an initial course of therapy as they are less than 20 visits. The request for postoperative physical therapy two times per week x 3 weeks to the Left Shoulder is medically necessary.