

Case Number:	CM15-0005873		
Date Assigned:	01/26/2015	Date of Injury:	03/14/2013
Decision Date:	03/18/2015	UR Denial Date:	12/29/2014
Priority:	Standard	Application Received:	01/12/2015

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: California

Certification(s)/Specialty: Physical Medicine & Rehabilitation

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 57 year old male who sustained an industrial injury, reported on 3/14/2013. He has reported low back and right shoulder pain. The diagnoses have included shoulder strain; lumbar strain; right shoulder impingement syndrome; SLAP repair; and lumbar disc protrusion. Treatments to date have included consultations; diagnostic and imaging studies; right shoulder surgery with post-surgical physical therapy; acupuncture therapy; and medication management. The status classification for this injured worker (IW) was noted to be temporarily totally disabled. The PR-2, dated 12/9/2014, notes that 12 physical therapy sessions were completed, 3.5 months post-op left shoulder surgery. On 12/26/2014 Utilization Review (UR) non-certified, for medical necessity, the request, made on 12/12/2014; for 12 physical therapy sessions for the right shoulder (3 x a week x 4 weeks). The Medical Treatment Utilization Schedule, post-surgical rehabilitation guidelines, was cited.

IMR ISSUES, DECISIONS AND RATIONALES

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

Physical therapy for the right shoulder, 12 weeks: Overturned

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

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

Decision rationale: This patient presents with lower back pain and right shoulder pain and is s/p right shoulder arthroscopic subacromial decompression, synovectomy and debridement from 8/28/14. The treater has asked for PHYSICAL THERAPY FOR THE RIGHT SHOULDER, 12 WEEKS on 11/11/14 . The 11/11/14 report specifies request further as physical therapy for the right shoulder 3 times a week for 4 weeks for active range of motion and strengthening. The patient had 12 physical therapy sessions for the right shoulder with unspecified efficacy per 11/11/14 report. MTUS guidelines state for rotator cuff syndrome/Impingement syndrome and arthroscopic shoulder surgery, post surgical treatment of 24 visits over 14 weeks is recommended over a treatment period of 6 months. In this case, the patient had ongoing right shoulder pain and is 3 months s/p shoulder surgery. The patient had 12 recent sessions of postoperative physical therapy and a short course of treatment may be reasonable for a flare-up, declined function or new injury. Prior physical therapy had unknown efficacy. The treater is requesting an additional 12 sessions for range of motion and strengthening. The requested additional 12 sessions seem reasonable and are within MTUS guidelines. The request IS medically necessary.