

Case Number:	CM15-0182556		
Date Assigned:	09/30/2015	Date of Injury:	01/25/2015
Decision Date:	11/09/2015	UR Denial Date:	09/10/2015
Priority:	Standard	Application Received:	09/16/2015

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 53 year old male who sustained an industrial injury on 01-25-2015. On 04-28-2015, the injured worker underwent arthroscopic surgery of the right shoulder. According to a progress report dated 08-14-2015, the injured worker continued to have pain to his right shoulder. He reported that with therapy, his mobility had improved but pain persisted especially when he did certain movement. He also reported pain to his right wrist. Objective findings included healed surgical scars of the right shoulder, no shoulder instability, positive impingement sign and weakness to the right shoulder internal fixation, external rotation and abduction. Examination of the right wrist revealed tenderness to palpation over the scaphoid tuberosity. There was tenderness over the anatomy snuffbox. Grip strength and pinch strength was diminished. X-ray of the right wrist showed no evidence of scaphoid fracture. Diagnoses included status post right shoulder rotator cuff repair and right wrist sprain. The treatment plan included physical therapy 2 times a week for 6 weeks, subacromial steroid injection and a follow up appointment in 6 weeks. According to a daily therapy note dated 09-08-2015, the injured worker "displayed a reduction in pain level". Tolerance to manual therapy was "favorable". Response to manual therapy revealed a "range of motion increase". The treatment plan included: continue with manual therapy, moist heat, cryotherapy, soft tissue mobilization, aerobic capacity conditioning, strength and resistive conditioning and electrical muscle stimulation. Therapy notes submitted for review included 18 sessions from 07-02-2015 to 09-08-2015. An authorization request dated 09-02-2015 was submitted for review. The requested services included primary treating physician follow up evaluation and physical therapy 2 times a week for 6 weeks. On 09-10-2015, Utilization Review non-certified the request for physical therapy

2 times a week for 6 weeks and follow up evaluation.

IMR ISSUES, DECISIONS AND RATIONALES

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

Physical therapy 2 times a week for 6 weeks: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS Postsurgical Treatment 2009, Section(s): Shoulder.

Decision rationale: Review indicates the patient is s/p shoulder arthroscopic rotator cuff repair on 4/28/15. The Chronic Pain Guidelines allow for physical therapy with fading of treatment to an independent self-directed home program. The employee has received at least 24 post-op PT visits; however without specific demonstrated evidence of functional improvement to allow for additional therapy treatments. Post-surgical guidelines allow for up to 24 visits post arthroscopic rotator cuff repair over 14 weeks over a 6-month rehab period. However, there is no clear measurable evidence of progress with the PT treatment already rendered including milestones of increased ROM, strength, and functional capacity. Review of submitted physician reports show no evidence of functional benefit, unchanged chronic symptom complaints, nonspecific clinical findings, and work status. There is no evidence documenting functional baseline with clear goals to be reached and the patient striving to reach those goals. The Physical therapy 2 times a week for 6 weeks is not medically necessary and appropriate.

Follow up evaluation: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Physical Medicine.

Decision rationale: Review indicates the patient is s/p shoulder arthroscopic rotator cuff repair on 4/28/15. The Chronic Pain Guidelines allow for physical therapy with fading of treatment to an independent self-directed home program. The employee has received at least 24 post-op PT visits; however without specific demonstrated evidence of functional improvement to allow for additional therapy treatments. Post-surgical guidelines allow for up to 24 visits post arthroscopic rotator cuff repair over 14 weeks over a 6-month rehab period. However, there is no clear measurable evidence of progress with the PT treatment already rendered including milestones of increased ROM, strength, and functional capacity. Review of submitted physician reports show no evidence of functional benefit, unchanged chronic symptom complaints, nonspecific clinical findings, and work status. There is no evidence documenting functional baseline with clear goals to be reached and the patient striving to reach those goals. As the request for Physical therapy 2

times a week for 6 weeks is not medically necessary and appropriate; thereby, the Follow up evaluation is not medically necessary and appropriate.