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| Case Number: | CM15-0037731 | | |
| Date Assigned: | 03/06/2015 | Date of Injury: | 06/04/2014 |
| Decision Date: | 04/20/2015 | UR Denial Date: | 02/10/2015 |
| Priority: | Standard | Application Received: | 02/27/2015 |

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 60 year old male, who sustained a work/ industrial injury as a truck driver on 6/4/14 resulting in a full thickness retracted tear of the supraspinatus tendon. Mechanism of injury was not documented. He has reported symptoms of right shoulder pain with weakness rated 4/10. Prior medical history includes an arm fracture (2005) and syncope. The diagnoses have included s/p left rotator cuff repair, right shoulder region disorder, sprain of the right rotator cuff, and right synovitis. Treatments to date included medication, steroid injection, and physical therapy. Medications included Etodolac, Tramadol, and Norco. The treating physician's report (PR-2) from 1/29/15 indicated the injured worker had regressed in status. There was increased pain with overhead motion and some weakness in the shoulder. The symptoms were localized, non-radicular, increased with activity and improved with rest. Exam noted right shoulder range of motion in forward elevation was at 140 degrees while external rotation was at 60 degrees. The internal rotation was at 20 degrees, Impingement test was positive. On 2/10/15, Utilization Review non-certified Physical Therapy, Right shoulder, 2 times per week for 6 weeks (12) citing the California Medical Treatment Utilization Schedule (MTUS), ACOEM Guidelines: Chronic Pain.

IMR ISSUES, DECISIONS AND RATIONALES

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

Physical Therapy, Right shoulder, 2 times per week for 6 weeks (12): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Postsurgical Treatment Guidelines Page(s): 10, 26-27.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical medicine Page(s): 98-99, Postsurgical Treatment Guidelines Page(s): 26-27.

Decision rationale: The patient presents with right shoulder pain, rated 4/10. The request is for PHYSICAL THERAPY R. SLIT SHOULDER, 2 TIMES PER WEEK FOR 6 WEEKS. Patient is status post right rotator cuff repair and subacromial decompression surgery 09/05/14. Physical examination to the right shoulder on 01/05/15 revealed tenderness to palpation and weakness. Range of motion was decreased 20%. Patient's treatments have included shoulder injection on 01/29/15 and physical therapy. Patient's diagnosis per 01/20/15 progress report include shoulder region DIS NEC R, sprain rotator cuff R, and synovitis NEC R. Per 09/04/14 progress report, patient's medications include Tramadol, Norco and Zofran. Patient's work status is modified duties. MTUS, post-surgical guidelines pages 26-27: Sprained shoulder; rotator cuff (ICD9 840; 840.4): Postsurgical treatment (RC repair/acromioplasty): 24 visits over 14 weeks. Postsurgical physical medicine treatment period: 6 months. MTUS page 98 and 99 has the following: "Physical medicine: Recommended as indicated below. Allow for fading of treatment frequency (from up to 3 visits per week to 1 or less), plus active self-directed home physical medicine". MTUS Guidelines page 98 and 99 states that for myalgia and myositis, 9 to 10 visits are recommended over 8 weeks, and for neuralgia, neuritis, and radiculitis, 8 to 10 visits are recommended. Treater has not provided reason for the request. Patient is within post operative time period, as right shoulder surgery was on 09/05/14. Based on the UR letter, the patient has completed 35 sessions of physical therapy following shoulder surgery. It would appear that the patient has had adequate post-operative therapy and the treater has not provided documentation or discussion on why additional physical therapy is needed, nor indicated why patient cannot move on to home therapy program. Furthermore, the requested 12 sessions of physical therapy exceeds what is allowed by MTUS for patient's condition. Therefore, the request IS NOT medically necessary.