MAXIMUS Federal Services

Case Number:	CM14-0017970		
Date Assigned:	04/16/2014	Date of Injury:	09/18/2012
Decision Date:	07/11/2014	UR Denial Date:	02/10/2014
Priority:	Standard	Application Received:	02/12/2014

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 Internal Medicine and is licensed to practice in New York. 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 patient is a 57 year old male who was injured on 09/18/2012 while lifting a heavy drill at work injuring his right shoulder. His diagnoses are right shoulder pain, cervical pain and thoracic pain. Prior treatment history has included the patient undergoing a right arthroscopic rotator cuff repair on 03/13/2013 followed by arthroscopic shoulder debridement in October of 2013. He had a course of physical therapy. The patient's medications include Norco 10/325mg, Acetaminophen with codeine, Hydrocodone 10-325mg, and Omeprazole. Physical therapy progress note dated 01/24/2014 documented the patient shows signs of improvement with improved rotator cuff strength, internal and external rotation would be rated at 4-/5, shoulder flexion remains his biggest problem and that strength would be rated 3-/5. Range of motion remains mildly limited with forward flexion actively. Internal and external rotation is near normal. Progress note dated 03/26/2014 documented the patient's complaint is inability to lift both arms above the shoulder level and constant pain. Objective findings on exam reveal his surgical incision on the right shoulder is healed. Deltoid function is intact bilaterally. On range of motion testing, active forward flexion on the right is 15 degrees and left 110 degrees, active abduction on right 50 degrees and left 95 degrees, active external rotation right 0 degrees and left 15 degrees. He is primarily able to internally rotate to the lumbosacral junction bilaterally. Passive forward flexion on the right is 120 degrees. He has a large amount of crepitus with passive range of motion of both shoulders. He has a positive impingement sign bilaterally. Manual muscle strength testing reveals 3/5 for forward flexion, abduction and Jobe testing bilaterally. External rotation on the right is 5 and on the left 3, internal rotation on right 5 and left is 3, external rotation right 90 degrees and left is 4. He is unable to perform dynamometer testing on the right today and on the left his power is 10.3 pounds. His lift-off test is not testable

on the right side and his belly-press is negative on the right side. The treating provider has requested physical therapy 2 x weeks x 4 weeks for the cervical spine, thoracic spine and right shoulder.

IMR ISSUES, DECISIONS AND RATIONALES

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

PHYSICAL THERAPY 2 X PER WEEK FOR 4 WEEKS ON CERVICAL SPINE, THORACIC SPINE AND RIGHT SHOULDER: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Page(s): 98-99, Postsurgical Treatment Guidelines Page(s): 27. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder Chapter.

Decision rationale: As per CA MTUS chronic pain medical guidelines, physical therapy is based on the philosophy that therapeutic exercise and/or activity are beneficial for restoring flexibility, strength, endurance, function, range of motion, and can alleviate discomfort. In this case, this patient is status post right shoulder rotator cuff repair on 03/13/2013 and continues to have pain and weakness. The patient was diagnosed with cervical pain, thoracic pain, and right shoulder pain. The patient has been treated with postop physical therapy. The Physical Therapy progress report dated 01/24/2014 indicates that the patient continues to show signs with improved rotator cuff strength and ROM (Range Of Motion) remains mildly limited forward flexion and near normal external and internal rotation; however, the total number of physical therapy sessions previously completed is unknown. Also, the medical records do not document cervical and thoracic spine physical exam findings to determine current functional deficits. Thus, the request for eight (8) physical therapy sessions on cervical spine, thoracic spine and right shoulder are not medically necessary and appropriate.