

Case Number:	CM14-0041201		
Date Assigned:	06/27/2014	Date of Injury:	01/31/2002
Decision Date:	09/18/2014	UR Denial Date:	03/25/2014
Priority:	Standard	Application Received:	04/07/2014

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 Physical Medicine and Rehabilitation, and is licensed to practice in California. 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:

This patient sustained an injury on 1/31/2002 while employed by [REDACTED]. Request(s) under consideration include Physical therapy 2 times a week for 4 weeks for right shoulder. Report (undated) from the provider with RFA dated 2/18/14 noted patient presented for follow-up of right shoulder pain s/p revision rotator cuff repair on 10/16/13; being followed by pain management; patient requesting to continue PT. Objective findings briefly noted, "patient still has shoulder pain/ stiffness/ weakness" (unspecified muscle or grading). Diagnoses include right rotator cuff bursitis/ tendinitis. Treatment included patient to remain off work another 6 weeks and to continue with PT. Therapist report dated 3/24/14 noted exam findings of right shoulder range on 1/29/14 with flex/abd/ER/IR of 147/140/77/71 with range on 3/24/14 of 140/145/88/61 degrees respectively with motor strength unchanged from 2 months prior after having undergone 34 PT sessions since 10/31/13 for s/p RCR revision with acromioplasty/ chondromalacia. Request(s) for Physical therapy 2 times a week for 4 weeks for right shoulder was non-certified on 3/25/14 citing guidelines criteria and lack of medical necessity.

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 4 weeks for right shoulder: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Therapy, pages 98-99, Physical Medicine Guidelines -Allow for fading of treatment frequency (from up to 3 visits per week to 1 or less), plus active self-directed home Physical Medicine. Myalgia and myositis, unspecified (ICD9 729.1): 9-10 visits over 8 weeks Neuralgia, neuritis, and radiculitis, unspecified (ICD9 729.2) 8-10 visits over 4 weeks Page(s): 98-99,.

Decision rationale: This patient sustained an injury on 1/31/2002 while employed by [REDACTED]. Request(s) under consideration include Physical therapy 2 times a week for 4 weeks for right shoulder. Report (undated) from the provider with RFA dated 2/18/14 noted patient presented for follow-up of right shoulder pain s/p revision rotator cuff repair on 10/16/13; being followed by pain management; patient requesting to continue PT. Objective findings briefly noted, "Patient still has shoulder pain/ stiffness/ weakness" (unspecified muscle or grading). Diagnoses include right rotator cuff bursitis/ tendinitis. Treatment included patient to remain off work another 6 weeks and to continue with PT. Therapist report dated 3/24/14 noted exam findings of right shoulder range on 1/29/14 with flex/abd/ER/IR of 147/140/77/71 with range on 3/24/14 of 140/145/88/61 degrees respectively with motor strength unchanged from 2 months prior after having undergone 34 PT sessions since 10/31/13 for s/p RCR revision with acromioplasty/ chondromalacia. Request(s) for Physical therapy 2 times a week for 4 weeks for right shoulder was non-certified on 3/25/14 citing guidelines criteria and lack of medical necessity. The Chronic Pain Guidelines allow for physical therapy with fading of treatment to an independent self-directed home program. The patient has received at least 34 PT visits for the arthroscopic repair over 9-1/2 months ago without demonstrated evidence of functional improvement to allow for additional therapy treatments. Chronic Pain Guidelines, post-operative therapy allow for 24 visits over 14 weeks for shoulder arthroscopy with postsurgical physical medicine treatment period of 6 months. Submitted reports have not adequately demonstrated the indication to support further physical therapy beyond the guidelines criteria. There is no clear specific functional improvement in ADLs, work status, or decrease in medication and utilization without change in neurological compromise or red-flag findings to support further treatment. The Physical therapy 2 times a week for 4 weeks for right shoulder is not medically necessary and appropriate.