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| Case Number: | CM15-0016753 | | |
| Date Assigned: | 02/05/2015 | Date of Injury: | 07/21/2013 |
| Decision Date: | 03/30/2015 | UR Denial Date: | 01/19/2015 |
| Priority: | Standard | Application Received: | 01/29/2015 |

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: Maryland

Certification(s)/Specialty: Physical Medicine & Rehabilitation, Neuromuscular Medicine

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 55 year old male/female, who sustained a work/ industrial injury on 7/21/13. She has reported symptoms of pain in right shoulder and upper arm. Prior medical history includes hypertension. The diagnoses have included rotator cuff syndrome, impingement syndrome. Treatment to date has included conservative measures, medication, surgery, medication, home exercise program, and physical therapy. The treating physician's progress report dated 11/24/14 noted the IW being seen post right shoulder arthroscopy of subacromial decompression, post surgery on the right distal clavicle resection, post right rotator cuff repair. The symptoms had improved with occasional achiness and weakness. There was subacromial tenderness present with range of motion forward flexion of 0-160 degrees, active abduction of 0-160 degrees, active external rotation 0-60 degrees, active internal rotation of 0-60 degrees, and supraspinatus strength of 4/5. Plan was for physical therapy for strengthening. On 1/19/15, Utilization Review non-certified: Physical Therapy re-evaluation for the right shoulder (QTY: 1); Additional Physical Therapy 3 x weekly for 4 weeks for the right shoulder (QTY: 12), noting the California Medical treatment Utilization Schedule (MTUS) Guidelines.

IMR ISSUES, DECISIONS AND RATIONALES

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

Physical therapy re-evaluation for the right shoulder QTY: 1.00: Upheld

Claims Administrator guideline: Decision based on MTUS Postsurgical Treatment Guidelines Page(s): 27.

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

Decision rationale: Physical therapy re-evaluation for the right shoulder QTY: 1.00 is not medically necessary per the MTUS Guidelines. The MTUS Post Surgical Guidelines recommend up to 24 visits of PT over 6 months for this surgery. The documentation indicates that the patient has had this amount of therapy. There are no extenuating circumstances documented that would require an additional 12 visits of supervised PT. The MTUS recommends transitioning to an independent home exercise program. Therefore the request for physical therapy re-evaluation for the right shoulder QTY: 1.00 is not medically necessary.

Additional physical therapy 3x weekly for 4 weeks for the right shoulder QTY: 12.00:
Upheld

Claims Administrator guideline: Decision based on MTUS Postsurgical Treatment Guidelines Page(s): 27.

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

Decision rationale: Additional physical therapy 3x weekly for 4 weeks for the right shoulder QTY: 12.00 is not medically necessary per the MTUS Guidelines. The MTUS Post Surgical Guidelines recommend up to 24 visits of PT over 6 months for this surgery. The documentation indicates that the patient has had this amount of therapy. There are no extenuating circumstances documented that would require an additional 12 visits of supervised PT. The MTUS recommends transitioning to an independent home exercise program. Therefore the request for additional physical therapy 3x weekly for 4 weeks for the right shoulder QTY: 12.00 is not medically necessary.