

Case Number:	CM15-0060783		
Date Assigned:	04/07/2015	Date of Injury:	05/28/2003
Decision Date:	06/11/2015	UR Denial Date:	03/24/2015
Priority:	Standard	Application Received:	03/31/2015

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: Minnesota, Florida
 Certification(s)/Specialty: Orthopedic Surgery

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 56 year old female, who sustained an industrial injury on May 28, 2003. The injured worker had reported left shoulder and knee pain. The diagnoses have included shoulder arthralgia, impingement of the shoulder, shoulder adhesive capsulitis, shoulder acromioclavicular joint arthritis, knee arthralgia and knee tendonitis status post total knee arthroplasty. Treatment to date for the shoulder has included medications, radiological studies, Cortisone injection, ice/heat treatment and a home exercise program. Current documentation dated January 19, 2015 notes that the injured worker reported left shoulder pain. The injured worker was noted to have had a Cortisone injection which was effective for a few days but the pain returned and was worse than before the injection. Examination of the left shoulder revealed tenderness, crepitus, a decreased range of motion and a positive impingement test. Left knee examination showed tenderness, decreased range of motion and negative special orthopedic testing. The treating physician's plan of care included a request for left shoulder surgery with associated surgical requests. The surgery was non-certified by utilization review as there was no MRI report submitted and no recent non-operative treatment with trial/failure was documented. An additional request was for physical therapy two-three times weekly for four to six weeks to the left knee per request for authorization (referred to as left shoulder on the IMR request) and post-operative physical therapy #12 to the left shoulder.

IMR ISSUES, DECISIONS AND RATIONALES

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

Physical Therapy, 2-3 times weekly for 4-6 weeks, Left Shoulder: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Page(s): 98-99.

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

Decision rationale: According to the RFA and progress note this request pertains to the left total knee arthroplasty and not the shoulder. However the guidelines are the same for both. With regard to the request for physical therapy for the left knee, chronic pain guidelines are used. Active therapy requires an internal effort by the individual to complete a specific exercise or task. This type of therapy may require supervision from a therapist or medical provider. Patients are instructed and expected to continue active therapies at home as an extension of the treatment process in order to maintain improvement levels. The guidelines allow for fading of treatment frequency from up to 3 visits per week to one or less plus active self-directed home physical medicine. For myalgia and myositis, unspecified, 9-10 visits over 8 weeks are recommended. The request as stated for 18 visits is not supported by guidelines and as such, the request is not medically necessary.

Post-operative Physical Therapy, Left Shoulder: Upheld

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

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

Decision rationale: Progress notes dated 1/19/2015 indicate that the injured worker is a 56-year-old female complaining of left shoulder pain. She stated that the cortisone shot lasted a few days and pain returned. Examination of the left shoulder revealed subacromioclavicular tenderness and deltoid tenderness. Impingement testing was positive. There was a crepitus palpated with range of motion. Abduction was 130 and forward flexion 150. Internal and external rotation were normal. Motor strength was normal. Examination of the left knee revealed an antalgic gait and difficulty squatting or rising on the toes or heels. There was a well-healed incision of a total knee arthroplasty. Alignment was neutral. There was patellofemoral tenderness. Range of motion was 0-95 on the left and 0-115 on the right. The diagnosis was acromioclavicular arthritis and impingement with supraspinatus strain, left shoulder, adhesive capsulitis and shoulder synovitis. Authorization was requested for video arthroscopy of the left shoulder, possible rotator cuff repair, subacromial decompression, debridement, acromioplasty, and facial sheath injection, cold flow therapy and arc sling and postoperative physical therapy x 12 visits. There was an additional request for authorization for physical therapy 2-3 times a week x 4-6 weeks for increased range of motion and strengthening of left knee using all modalities for quad tendinitis. Utilization review denied the request for shoulder arthroscopy with possible rotator

cuff repair, subacromial decompression and debridement, acromioplasty, facial sheath injection. There was no documentation of a nonoperative rehabilitation protocol with injections, medication, exercises and the outcome. Furthermore, there was no MRI report necessitating the requested surgery. The associated surgical requests were also non-certified. California MTUS guidelines indicate surgical considerations for activity limitation for more than 4 months post existence of a surgical lesion, failure to increase range of motion and strength of the musculature around the shoulder even after exercise programs plus existence of a surgical lesion, and clear clinical and imaging evidence of a lesion that has been shown to benefit, in both the short and long term, from surgical repair. The documentation provided does not include any imaging studies or evidence of a non-operative comprehensive rehabilitation program with injections/exercises as necessitated by guidelines for impingement syndrome. Surgery for impingement syndrome is usually arthroscopic decompression. This procedure is not indicated for patients with mild symptoms or those with no activity limitations. Conservative care including cortisone injections can be carried out for at least 3-6 months before considering surgery. 2 or 3 subacromial injections of local anesthetic and cortisone preparation over an extended period as part of an exercise rehabilitation program to treat rotator cuff inflammation, impingement syndrome, or small tears. A rotator cuff repair is indicated after firm diagnosis is made and rehabilitation efforts have failed. Since the surgical procedure has been non-certified, the requested post-surgical physical therapy is no longer medically necessary per guidelines. As such, the medical necessity of the requested post-operative physical therapy is not established.