

Case Number:	CM13-0030851		
Date Assigned:	11/27/2013	Date of Injury:	06/28/2012
Decision Date:	02/06/2014	UR Denial Date:	09/25/2013
Priority:	Standard	Application Received:	10/01/2013

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Occupational Medicine, 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 physician 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 applicant is a represented [REDACTED] employee who has filed a claim for chronic shoulder pain, low back pain, and bicipital tendonitis associated with an industrial injury that took place on June 28, 2012. Thus far, the applicant has been treated with analgesic medications, transfer of care to and from various providers in various specialties, a shoulder corticosteroid injection, and extensive periods of time off of work. A November 26, 2013 letter notes that the applicant is off of work owing to shoulder pain. She has not worked since October 7, 2013. She has good shoulder muscle mass and strength, but does have pain with motion. It is stated that she may have a labral tear versus impingement syndrome. She underwent a shoulder corticosteroid injection. A note dated November 13, 2013 states that the applicant is having increased right shoulder pain. She is on Naprosyn and Percocet. A 4/5 right upper extremity strength is appreciated secondary to pain. Motion is also limited secondary to pain.

IMR ISSUES, DECISIONS AND RATIONALES

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

request for eight sessions of physical therapy: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines.

Decision rationale: As noted on page 8 of the MTUS Chronic Medical Treatment Guidelines, there must be some demonstration of functional improvement at various milestones in the treatment program to justify continued treatment. In this case, the applicant has had prior unspecified amounts of physical therapy over the life of the claim. There has been no demonstration of functional improvement in terms of the parameters established in MTUS 9792.20f. The applicant remains off of work, on total temporary disability. She remains quite reliant on various medications, including Naprosyn and Percocet, and injections further arguing against functional improvement as defined in section 9792.20f. Continuing physical therapy in this context is not indicated here. Therefore, the request is not certified.