

Case Number:	CM13-0053076		
Date Assigned:	12/30/2013	Date of Injury:	04/20/2010
Decision Date:	08/29/2014	UR Denial Date:	11/07/2013
Priority:	Standard	Application Received:	11/18/2013

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 Anesthesiology, has a subspecialty in Pain 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 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 injured worker is a 58 year old female who sustained an injury to her right shoulder on 04/20/10. The most recent clinical note dated 11/05/13 reported that the injured worker continued to complain of pain in the left shoulder following the previous injection. She did not get functional improvement and pain relief with therapy/medications. Physical examination noted positive tenderness over the paracervical musculature; motor strength 5/5 in all muscle groups of the bilateral upper extremities; neurovascularly intact; range of motion flexion chin to chest, extension 30 degrees, bilateral lateral bending 30 degrees, bilateral rotation 30 degrees; reflexes 2+ throughout; positive Neer's and Hawkins' testing of the left shoulder; positive crepitus; positive greater tuberosity and acromioclavicular joint tenderness; positive acromioclavicular joint compression and cross over test. The injured worker was diagnosed with left shoulder calcific tendonitis, impingement syndrome of the left shoulder, right shoulder compensatory pain, and right shoulder impingement syndrome. The injured worker was recommended to continue physical therapy to address remaining functional deficits.

IMR ISSUES, DECISIONS AND RATIONALES

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

PHYSICAL THERAPY THREE (3) TIMES A WEEK FOR SIX (6) WEEKS FOR THE RIGHT SHOULDER: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder chapter, Physical therapy.

Decision rationale: The request for physical therapy 3 x a week x 6 weeks for the right shoulder is not medically necessary. Furthermore, the injured worker has had an unknown amount of physical therapy. A partial/modified certification for 2 visits of therapy were recommended to allow for limited re-treatment, reeducation and transition to a prescribed and self-administered protocol and appliance assessment. After reviewing the submitted documentation, there was no significant objective clinical information provided that would support reversing the previous adverse determination. Given this, the request for physical therapy 3 x a week x 6 weeks for the right shoulder is not indicated as medically necessary.