

Case Number:	CM13-0053669		
Date Assigned:	12/30/2013	Date of Injury:	05/09/2013
Decision Date:	03/20/2014	UR Denial Date:	11/12/2013
Priority:	Standard	Application Received:	11/18/2013

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 Physical Medicine & Rehabilitation, and is licensed to practice in Texas and Oklahoma. 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 patient is a 37-year-old male who reported injury on 05/09/2013. The mechanism of injury was not specified; however, the patient was noted to feel a sudden, sharp pain and popping in his left shoulder while at work. The patient had an MRI (magnetic resonance imaging) on 07/25/2013, which revealed tendinopathy or partial-thickness tear of the superficial fibers of the superior aspect of the subscapularis tendon of the left shoulder. The most recent examination note dated 09/13/2013 revealed the patient had difficulty of increased pain with reaching and lifting after a motor vehicle accident on 09/12/2013. The patient indicated that the pain in the shoulder was 4/10, and indicated it was more swollen. The patient indicated numbness on the lateral aspect of the shoulder, and that it occasionally radiated into the arm and forearm. The patient was noted to get occasional popping and clicking, and was unable to sleep on the left shoulder. The patient indicated relief in the past with physical therapy and would like to continue therapy. The patient's diagnosis was left shoulder partial rotator cuff tear with paresthesia in the left upper extremity deltoid area. The request was made for physical therapy for the shoulder, quantity 8.

IMR ISSUES, DECISIONS AND RATIONALES

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

Physical therapy shoulder, Qty: 8: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG).

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

Decision rationale: The California MTUS Guidelines indicate that physical medicine with passive therapy can provide short-term relief during the early phases of pain treatment and the recommendation is for a maximum of 9 to 10 visits for myalgia and myositis and 8 to 10 visits may be warranted for treatment of neuralgia, neuritis, and radiculitis. The clinical documentation submitted for review indicated the patient had previously been treated with physical therapy. There was a lack of documentation indicating the quantity of visits, as well as the objective functional benefit received from the physical therapy. There was a lack of documentation indicating objective functional deficits to support ongoing therapy. The patient's most recent physical therapy note dated 10/16/2013 revealed the patient had 4/5 muscle testing on the left in flexion, extension, abduction, adduction, internal rotation, and external rotation. The patient's range of motion was decreased in flexion, extension, internal rotation, and external rotation, as well as abduction. There was a lack of documentation indicating the quantity of sessions the patient had previously been treated with, and objective functional improvement, as well as remaining objective functional deficits. The request for physical therapy of the shoulder, quantity 8, is not medically necessary.

Interferential unit for home use: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Section Interferential Current Stimulation Page(s): 118-120.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Section Interferential Current Stimulation Page(s): 118.

Decision rationale: The California MTUS guidelines do not recommend Interferential Current Stimulation (ICS) as an isolated intervention. The clinical documentation submitted for review failed to indicate whether the unit would be for rental or purchase. Additionally, as the requested physical therapy, which was concurrently reviewed with this request was not medically necessary, the request for an Interferential unit for home use is not medically necessary.