

Case Number:	CM13-0053837		
Date Assigned:	12/30/2013	Date of Injury:	05/30/2011
Decision Date:	04/30/2014	UR Denial Date:	11/01/2013
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 Physical Medicine and Rehabilitation, has a subspecialty in Pain Medicine, and is licensed to practice in California and Virginia. 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 patient is a 47 year old female who was injured on 05/30/2011. The patient was injured while she was taping a box and felt a popping in her right shoulder. She continued to work. She felt a second pop in her right shoulder near her neck. She felt a strong pain where her shoulder had popped and it felt like she did not have any more strength in her right arm. Prior treatment history has included Norco, Tramadol, Diclofenac sodium, Theramine, Cymbalta, and Omeprazole; physical therapy, cortisone injection on 09/06/2011. The patient underwent an arthroscopic surgery on her right shoulder on 05/21/2012; an injection for shoulder arthrogram with Flouro guidance on 07/10/2013. Diagnostic studies reviewed include MRI of the right shoulder performed on 08/05/2011 revealed: 1. Hypertrophic tendinopathy of the supraspinatus tendon, but no tear 2. Minor tendinopathy of the infraspinatus tendon 3. Normal labrum; minor subcutaneous edema and subchondral cyst formation in the humeral head as described. QME dated 12/30/2011 states the patient is diagnosed with right shoulder sprain/strain with pain radiating to the cervical area and right elbow sprain/strain. He recommended that the patient undergo a second opinion with an orthopedic surgeon and stated the patient had not reached a permanent and stationary status with a need for future treatment. PR2 dated 10/15/2013 reported the patient complaints of right sided neck pain, right shoulder pain, and right arm pain with intermittent numbness in the hand. She is unable to specify exactly what fingers. Objective findings on examination of the cervical spine revealed noticeable swelling at the right trapezius. With direct palpation at the right paracervical and trapezius muscle and to the medial scapular border, she has exquisite tenderness with spasming and guarding. Forward flexion is 2 inches chin to chest; extension is 40 degrees; rotation to the left and the right is 40 degrees; lateral bending to the right is 40 degrees; to the left is 30 degrees. She is neurovascularly intact. The

DTRs of the upper extremities are 2+ bilaterally. The patient is recommended physical therapy for the cervical spine and PRP injection under ultrasound guidance to aid in healing of the tendon. She has good range of range of motion. She does not require MUA. A NCV/EMG study of the right upper extremity is requested.

IMR ISSUES, DECISIONS AND RATIONALES

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

PHYSICAL THERAPY FOR THE CERVICAL SPINE X 4: 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: Per the CA MTUS, Active therapy is based on the philosophy that therapeutic exercise and/or activity are beneficial for restoring flexibility, strength, endurance, function, range of motion, and can alleviate discomfort. The medical records submitted document the patient to have myofascial pain in the right shoulder and normal neurological strength in the right upper extremity. There is no documentation of decreased flexibility, strength, endurance or range of motion. There is no documentation regarding the therapy treatment plan and no functional goals documented. Based on the lack of documentation on the need for restoring the functions outlined, medical necessity has not been established.