

Case Number:	CM13-0067577		
Date Assigned:	01/03/2014	Date of Injury:	07/26/2005
Decision Date:	05/22/2014	UR Denial Date:	12/16/2013
Priority:	Standard	Application Received:	12/18/2013

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 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 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:

Review is for a 47 year old female who was involved in a work-related injury in 2005. Injuries include neck, left shoulder, left elbow, and bilateral wrists. Left shoulder acromioplasty with distal clavicle resection and rotator cuff repair was performed in October 2009, followed by subacromial injections x2 in May 2012 and October 2012. Examination reported dated 12/9/13 noted subjective complaints of right shoulder pain as a result of compensation from left shoulder injury, which was reported as pain free. Left shoulder ROM was noted as 140 flexion, 180 degrees abduction, 90 degrees internal rotation and 80 degrees external rotation. (+)crossimpingement sign. VAS pain scale for the right shoulder is 7/10 with functional ROM and motor strength testing graded as +3/5 bilaterally.

IMR ISSUES, DECISIONS AND RATIONALES

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

OUTPATIENT REPEAT CORTICOSTEROID INJECTION FOR THE LEFT SUBACROMIAL SHOULDER: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

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 Guidelines.

Decision rationale: According to the ODG treatment guidelines' criteria, physical therapy to the shoulder for diagnosis of impingement/rotator cuff syndrome is considered at 10 visits over 8 weeks. Medical documentation notes a 47 year old female who was involved in a work-related injury in 2005 with injury sustained to the neck, left shoulder, left elbow, and bilateral wrists. Left shoulder acromioplasty with distal clavicle resection and rotator cuff repair was performed in October 2009, followed by two subacromial injections in May 2012 and October 2012. Examination reported dated 12/9/13 noted subjective complaints of right shoulder pain as a result of compensation from left shoulder injury, which was reported as pain free on this date. VAS pain scale for the right shoulder is 7/10 with functional ROM and motor strength testing graded as +3/5 bilaterally. Diagnosis is documented as shoulder joint pain. No further examination findings were documented. The request is for physical therapy 2x/week for 3 weeks for the right shoulder is not considered medically necessary as right shoulder notes functional ROM is achieved, therefore, no functional or therapeutic benefit should be gained as a result of the requested care.

PHYSICAL THERAPY(PT) TWO(2) TIMES PER WEEK OVER THREE(3) WEEKS FOR THE RIGHT SHOULDER: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

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 Guidelines.

Decision rationale: According to the ODG treatment guidelines' criteria, physical therapy to the shoulder for diagnosis of impingement/rotator cuff syndrome is considered at 10 visits over 8 weeks. Medical documentation notes a 47 year old female who was involved in a work-related injury in 2005 with injury sustained to the neck, left shoulder, left elbow, and bilateral wrists. Left shoulder acromioplasty with distal clavicle resection and rotator cuff repair was performed in October 2009, followed by two subacromial injections in May 2012 and October 2012. Examination reported dated 12/9/13 noted subjective complaints of right shoulder pain as a result of compensation from left shoulder injury, which was reported as pain free on this date. VAS pain scale for the right shoulder is 7/10 with functional ROM and motor strength testing graded as +3/5 bilaterally. Diagnosis is documented as shoulder joint pain. No further examination findings were documented. The request is for physical therapy 2x/week for 3 weeks for the right shoulder is not considered medically necessary as right shoulder notes functional ROM is achieved, therefore, no functional or therapeutic benefit should be gained as a result of the requested care.