

Case Number:	CM14-0004048		
Date Assigned:	02/05/2014	Date of Injury:	01/15/2013
Decision Date:	06/20/2014	UR Denial Date:	12/30/2013
Priority:	Standard	Application Received:	01/10/2014

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:

The patient is a 64-year-old female who has submitted a claim for cervical sprain/strain, left shoulder bursitis/tendinitis, and acromioclavicular arthritis associated with an industrial injury date of 1/15/2013. The medical records from 2013 were reviewed, which showed constant pain to the front of her neck, radiating to her shoulder, upper arm, wrist and hand pain. This is associated with numbness, tingling, weakness, coldness and grip loss. She indicated intermittent upper, mid and low back pain that radiates to her legs. This is associated with stiffness and cramping. She has some difficulty in dressing, cutting her food, making a meal, and typing message on a computer. She was unable to wash and dry herself. A physical examination of the cervical spine showed discomfort at extremes range of motion and tenderness in left paraspinal musculature. Cervical compression testing in both flexion and extension is negative for radicular arm discomfort. An examination of left shoulder showed positive diffused tenderness anteriorly and over the acromioclavicular joint. Range of motion of shoulder is full with 170 degrees in abduction and forward flexion. External rotation is noted to be at 60 degrees bilaterally. The impingement and adduction signs were both positive. An MRI of the cervical spine and shoulder which was done on 5/6/13 showed disc degeneration, but no evidence of disc herniation in the cervical spine. An MRI of the shoulder documented some bursitis and tendinitis with no full thickness tears. The treatment to date has included, Subacromial Corticosteroid injections, and eight (8) sessions of physical therapy since 10/16/13. The medications which taken were Elavil 10 mg and Advil for pain. The utilization review from 12/30/13 denied the request for eight (8) physical therapy/aquatic therapy visits for the right shoulder, twice a week for four (4) weeks because previous records mentioned that she already completed eight (8) sessions of therapy. Since the handwritten progress report was poorly written, the exact progress and patient's response to therapy cannot be determined. Therefore, it was denied.

IMR ISSUES, DECISIONS AND RATIONALES

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

PROSPECTIVE REQUEST FOR 8 OUTPATIENT PHYSICAL THERAPY/AQUATIC THERAPY VISITS FOR THE RIGHT SHOULDER, TWICE A WEEK FOR 4 WEEKS:

Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation AMERICAN COLLEGE OF OCCUPATIONAL AND ENVIRONMENTAL MEDICINE (ACOEM), [HTTPS://WWW.ACOEMPRACGUIDES.ORG/SHOULDER](https://www.acoempracguides.org/shoulder); TABLE 2, SUMMARY OF RECOMMENDATIONS, SHOULDER DISORDERS.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation MTUS: CHRONIC PAIN MEDICAL TREATMENT GUIDELINES, 98-99.

Decision rationale: The Chronic Pain Guidelines indicate that physical medicine is recommended and that the given frequency should be tapered and transition into a self-directed home program. In this case, the patient had already completed eight (8) physical therapy sessions dated 10/16/2013. However, due to poor handwritten progress reports, the patient's response and functional benefits to therapy cannot be determined. In addition, there is no documentation regarding the necessity for additional physical therapy of the right shoulder. Therefore, the request for prospective eight (8) outpatient physical therapy/aquatic therapy visits for the right shoulder, twice a week for four (4) weeks is not medically necessary.