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| Case Number: | CM14-0004118 | | |
| Date Assigned: | 02/03/2014 | Date of Injury: | 04/12/2007 |
| Decision Date: | 06/20/2014 | UR Denial Date: | 12/23/2013 |
| Priority: | Standard | Application Received: | 01/09/2014 |

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 an employee of [REDACTED] and has submitted a claim for left shoulder pain and stiffness associated with an industrial injury date of April 12, 2007. Treatment to date has included left shoulder acromioplasty on March 23, 2011, physical therapy, and medications. Medical records from 2007-2014 were reviewed, the latest of which was a progress report dated January 29, 2014, which showed that the patient complained of severe pain and stiffness in his left shoulder. Physical examination revealed scar of previous surgery on the left shoulder. There was tenderness at the left acromioclavicular joint with hypertrophic changes. Also noted was tenderness at the subacromial region and in the direction of the rotator cuff. Abduction was to 90 degrees and adduction was to 15 degrees. External rotation was to 30 degrees and an internal rotation was to 30 degrees.

IMR ISSUES, DECISIONS AND RATIONALES

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

PHYSICAL THERAPY TWO TIMES PER WEEK FOR 6 WEEKS, LEFT SHOULDER:

Overturned

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation MTUS: 9792.23.2. SHOULDER COMPLAINTS, ,

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, 9792.24.2, PAGE 98-99

Decision rationale: According to pages 98-99 of the California MTUS Chronic Pain Medical Treatment Guidelines, active therapy is recommended for restoring flexibility, strength, endurance, function, and range of motion; it can also alleviate discomfort. Patients are instructed and expected to continue active therapies at home as an extension of the treatment process in order to maintain improvement levels. In addition, guidelines allow for fading of treatment frequency from up to three visits per week to one or less, plus the addition of active self-directed home physical medicine. In this case, the patient already completed 20 postsurgical physical therapy visits since 2011. He was status quo until 10/30/13, when there was a noted flare-up of left shoulder symptoms manifesting with pain and popping sensation. The patient was authorized with two sessions of physical therapy at that time; however, it only provided temporary relief. An extension of physical therapy may be necessary due to acute exacerbation of symptoms, corroborated by objective findings of tenderness and limited motion of the left shoulder. As such, the request is medically necessary.