

Case Number:	CM14-0103191		
Date Assigned:	09/24/2014	Date of Injury:	08/05/2011
Decision Date:	11/04/2014	UR Denial Date:	06/20/2014
Priority:	Standard	Application Received:	07/03/2014

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 Family Medicine and is licensed to practice in Texas and Mississippi. 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 injured worker is a 50-year-old female who reported an injury on 09/05/2011. The mechanism of injury was a slip and fall. The injured worker's diagnoses included right shoulder partial rotator cuff tear with impingement, bursitis, status post right shoulder diagnostic and operative arthroscopy, and history of left shoulder and wrist industrial injury. The injured worker's past treatments include surgery, physical therapy, and medications. The injured worker's diagnostic testing was not provided. The injured worker's surgical history included right shoulder arthroscopy on 01/27/2014. On the clinical note dated 06/18/2014, the injured worker complained of right shoulder pain rated 7/10 at worst and 0/10 at best. The injured worker had normal motor strength to the right shoulder. Range of motion to the right shoulder was 170 degrees flexion and 172 degrees abduction. The injured worker's medications was not provided. The request was for physical therapy 2x3 for the right shoulder. The rationale for the request was to restore full function and use in the right extremity. The request for authorization form was not submitted for review.

IMR ISSUES, DECISIONS AND RATIONALES

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

Physical Therapy 2x3 for the Right Shoulder: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints, Chronic Pain Treatment Guidelines Chronic Pain Medical Treatment Guidelines Page(s): 98-99.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines
PHYSICAL MEDICINE Page(s): 98-99..

Decision rationale: The request for physical therapy 2x3 for the right shoulder is not medically necessary. The injured worker is diagnosed with status post right shoulder rotator cuff tear with impingement and bursitis. The injured worker complains of right shoulder pain rated 0/10 to 7/10. The California MTUS Guidelines recommend 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 guidelines recommend 9 to 10 visits over 8 weeks. The medical records indicate the injured worker has received 24 visits of postoperative physical therapy. The injured worker has minimal functional deficit with range of motion of the right shoulder of flexion 170 degrees and abduction 172 degrees out of 180 degrees. The injured worker's motor strength in the right shoulder is slightly decreased with external rotation of 4/5. The injured worker's medical records lack documentation of significant objective functional deficits to warrant additional sessions of physical therapy. As such, the request for physical therapy 2x3 for the right shoulder is not medically necessary.