

Case Number:	CM14-0106356		
Date Assigned:	07/30/2014	Date of Injury:	03/03/2014
Decision Date:	08/29/2014	UR Denial Date:	06/20/2014
Priority:	Standard	Application Received:	07/09/2014

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 Anesthesiology, has a subspecialty in Pain Medicine and is licensed to practice in Florida. 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 with a reported date of injury on 03/03/2014; the mechanism of injury was a fall. The injured worker was diagnosed with backache and joint pain, localized in the right shoulder. Prior treatments included physical therapy. Diagnostic studies included an x-ray of the right shoulder, which was performed on 05/19/2014, and revealed mild to moderate degenerative changes. The clinical note dated 04/28/2014 noted the injured worker was seen for initial evaluation of a workplace injury. The provider indicated the injured worker had decreased range of motion. The injured worker reported pain to the right upper back and right upper extremity, which was localized and described as aching, with radiation to the right upper extremity. The injured worker reported pain rated 8/10. The provider indicated flexion was restricted and painful. The provider recommended the injured worker attend physical therapy. The physical therapy initial evaluation dated 05/05/2014 noted the injured worker's right shoulder range of motion-demonstrated flexion to 85 degrees with pain, and abduction to 90 degrees with pain. The provider indicated that the injured worker tolerated her initial treatment well. The injured worker had general pain and muscle guarding. The physical therapy note dated 05/28/2014 noted the injured worker completed six of six authorized treatments. The provider indicated the injured worker's right shoulder flexion was 112 degrees and abduction was 90 degrees. The provider indicated the injured worker's previous Oswestry pain questionnaire score was 70%, and it had increased to 72% as of 05/28/2014. The provider felt the injured worker had responded fairly well to physical therapy. The injured worker's medication regimen included Cyclobenzaprine HCL 5 mg (1 tablet at bedtime as needed) and Diclofenac Sodium 50 mg (1 tablet twice daily as needed). The physician's treatment plan included recommendations for continued physical therapy. The provider's rationale for the requested physical therapy was not

indicated. The Request for Authorization form for physical therapy of the right shoulder 2 times a week for 3 weeks was submitted on 04/28/2014.

IMR ISSUES, DECISIONS AND RATIONALES

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

Physical therapy 2 times a week for 3 weeks, right shoulder: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 203. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Physical Therapy.

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

Decision rationale: The request for physical therapy 2 times a week for 3 weeks, right shoulder is not medically necessary. The California MTUS guidelines note 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 allowing for fading of treatment frequency (from up to three visits per week to one or less), plus active self-directed home physical medicine. The guidelines recommend 8-10 sessions of physical therapy over 4 weeks. Per the provided documentation, the injured worker has participated in 6 sessions of physical therapy with improvements in shoulder flexion. The injured worker's shoulder flexion has improved from 90 degrees to 112 degrees. The request for six additional sessions would exceed the guideline recommendations. There is a lack of documentation indicating a more recent assessment of the injured worker's condition was performed, which documents significant objective functional deficits needing improvement with further physical therapy. Therefore, the request for physical therapy 2 times a week for 3 weeks, right shoulder is not medically necessary.