

Case Number:	CM14-0012383		
Date Assigned:	02/21/2014	Date of Injury:	09/07/2010
Decision Date:	07/25/2014	UR Denial Date:	01/21/2014
Priority:	Standard	Application Received:	01/30/2014

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 Management and is licensed to practice in Tennessee. 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 54-year-old female who has submitted a claim for right shoulder sprain/strain associated with an industrial injury date of 09/07/2010. Medical records from 08/16/2013 to 03/11/2014 were reviewed and showed that patient complained of chronic right shoulder pain (grade not specified) which was aggravated with repetitive movements associated with her work. Pain was accompanied by right shoulder weakness and numbness. Physical examination revealed decreased right shoulder ROM in all planes of movement. MMT of the right upper extremity was 5/5. MRI of the right upper extremity dated 03/15/2011 revealed right supraspinatus tendinosis. MRI of the right shoulder dated 11/27/2013 revealed acromioclavicular joint osteoarthropathy and supraspinatus tendinosis. EMG/NCV studies of the right upper extremity dated 05/04/2011 and 01/15/2014 revealed normal findings. Treatment to date has included physical therapy, massage, medications, ice/heat and a cortisone injection. Utilization review, dated 01/21/2014, denied the request for eighteen visits of physical therapy three times a week for six weeks to the right shoulder because there was no documentation of symptomatic or functional improvement from previous therapy sessions.

IMR ISSUES, DECISIONS AND RATIONALES

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

**PHYSIOTHERAPY, 3 TIMES A WEEK FOR 6 WEEKS TO THE RIGHT SHOULDER
QUANTITY: 18: Upheld**

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines.

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

Decision rationale: According to pages 98-99 of the CA MTUS Chronic Pain Medical Treatment Guidelines, active therapy is recommended for restoring flexibility, strength, endurance, function, range of motion, and can 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. Physical medicine guidelines allow for fading of treatment frequency from up to 3 visits per week to 1 or less plus active self-directed home physical medicine. In this case, the patient has undergone numerous physical therapies with unspecified amount of visits based on the medical records (08/16/2013). There was no discussion stating the reason why the patient cannot transition into independent HEP. Therefore the request for PHYSIOTHERAPY, THREE(3) TIMES A WEEK FOR SIX(6) WEEKS TO THE RIGHT SHOULDER QUANTITY: EIGHTEEN (18) is not medically necessary.