

Case Number:	CM14-0018854		
Date Assigned:	04/23/2014	Date of Injury:	02/01/2012
Decision Date:	07/03/2014	UR Denial Date:	02/03/2014
Priority:	Standard	Application Received:	02/14/2014

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 Physical Medicine and Rehabilitation 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 injured worker is a 56 year old female with a reported date of injury on 02/01/2012; the mechanism of injury was not documented within the clinical documentation. The injured worker stated that her work required use of the right upper extremity for moving items which could weigh as much as 16 -17 pounds. The injured worker complained that she had pain in the right side of her neck, and right shoulder radiating into the entire right upper extremity which was intermittent and could reach level of moderate (6 on a scale of 0/10). The injured worker stated that in January 2013 she noticed pain in the right upper extremity primarily in the right shoulder which had progressively gotten worse. The injured worker stated she had not noticed any improvement from the physical therapy and chiropractic treatment. The injured worker also stated the radial portion became more restricted over time. The injured worker maintained the right shoulder at 90 degrees of adduction against examiners resistance; however, it caused pain in the sub deltoid and bicipital groove area. The injured workers range of motion of the cervical spine demonstrated flexion to 50 degrees, extension to 60, and rotation on the right to 80 degrees and on the left to 80 degrees, lateral bending 45 to degrees bilaterally. Range of motion of the shoulder showed extension on the right to 40 degrees and on the left to 40 degrees, flexion on the right to 155 degrees, and on the left to 150 degrees, abduction on the right to 160 degrees, and on the left to 150 degrees, adduction bilaterally to 30 degrees, internal rotation to L5 on the right and on the left to 80 degrees, external rotation bilaterally to 90 degrees. The injured worker had x-rays of the right shoulder which reported chronic osteoarthritic changes in the shoulder, suspected rotator cuff, and tendonitis with dystrophic calcification near the insertion site. The injured worker had diagnoses including right shoulder sub acromial bursitis, chronic with evidence of dystrophic calcification of rotator cuff (per x-ray) and bicipital tendonitis, right shoulder. The medical doctor recommended that the injured worker have an injection of

corticosteroids to the right shoulder; the injured worker declined and did not wish to take any medications. The request for authorization was submitted 01/27/2014.

IMR ISSUES, DECISIONS AND RATIONALES

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

PHYSICAL THERAPY, EVALUATE AND TREAT, 2 X WEEK FOR 3 WEEKS FOR THE RIGHT SHOULDER: Upheld

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

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

Decision rationale: The California MTUS Guidelines state that 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. Active therapy requires an internal effort by the individual to complete a specific exercise or task. The guidelines recommend allowing for fading of treatment frequency, from up to 3 visits per week to 1 or less. Injured workers should participate in an active self-directed home physical medicine programs. The injured worker was seen on a follow up visit on 01/14/2014 and reported pain to the right side of the shoulder. The patient stated that she had physical therapy in the past which was not helpful. The injured worker stated that she did not wish to take any medication or corticosteroid injections. The medical records indicated that the injured worker reports that past physical therapy was not helpful; there was a lack of documentation from the requesting physician indicating the injured worker had significant objective functional improvement with the prior therapy in order to justify further treatment. There was a lack of a recent documented adequate and complete assessment of the injured workers current condition. Given the reported failure of past therapy and the lack of objective documentation, the guidelines would not support the requested additional physical therapy. The request for physical therapy, evaluate and treat, 2 x week for 3 weeks for the right shoulder is not medically necessary.