

Case Number:	CM14-0180293		
Date Assigned:	11/04/2014	Date of Injury:	01/31/2014
Decision Date:	12/10/2014	UR Denial Date:	10/13/2014
Priority:	Standard	Application Received:	10/30/2014

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 Occupational Medicine and is licensed to practice in Iowa. 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:

This injured worker is a 34 year old employee with date of injury 1/31/14. Medical records indicate the injured worker is undergoing treatment for right shoulder pain due to right rotator cuff tear and right humerus benign bone cyst. Subjective complaints include intermittent dull, throbbing and mild sharp pain in right shoulder which radiates up into the neck and down the right arm. Pain is exacerbated by movement and disturbs injured workers sleep. Objective complaints include MRI showing blastic lesion of the right proximal humerus and rotator cuff tear. On exam has tenderness of the subacromial space. He has positive Hawkins and Neer's signs. Decrease in range of motion of the shoulder joint. Treatment has consisted of Norco, Ibuprofen, Ultram and Biofreeze. Cortisone injection and physical therapy 3 times a week for 2 weeks. Arthroscopy with debridement and lysis of adhesions, synovectomy, subacromial decompression with acromioplasty. The utilization review determination was rendered on 10/13/14 recommending non certification of physical therapy 3 times a week for 6 weeks, 18 sessions.

IMR ISSUES, DECISIONS AND RATIONALES

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

18 Physical Therapy Sessions 3 Times a Week for 6 Weeks: Upheld

Claims Administrator guideline: Decision based on MTUS Postsurgical Treatment Guidelines.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Therapy, Physical Medicine Page(s): 98-99. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Shoulder (Acute & Chronic), Physical Therapy, ODG Preface - Physical Therapy

Decision rationale: California MTUS guidelines refer to physical medicine guidelines for physical therapy. "Allow for fading of treatment frequency (from up to 3 visits per week to 1 or less), plus active self-directed home Physical Medicine." Regarding physical therapy, ODG states "Patients should be formally assessed after a "six-visit clinical trial" to see if the patient is moving in a positive direction, no direction, or a negative direction (prior to continuing with the physical therapy); & (6) When treatment duration and/or number of visits exceeds the guideline, exceptional factors should be noted." At the conclusion of this trial, additional treatment would be assessed based upon documented objective, functional improvement, and appropriate goals for the additional treatment. The request for 18 sessions is far in excess of the initial trials per MTUS and ODG guidelines. As such, the request for 18 Physical Therapy Sessions 3 Times a Week for 6 Weeks is not medically necessary.