

Case Number:	CM14-0034078		
Date Assigned:	06/20/2014	Date of Injury:	03/11/2013
Decision Date:	07/24/2014	UR Denial Date:	03/03/2014
Priority:	Standard	Application Received:	03/18/2014

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 patient is a 51-year-old who was injured on March 11, 2013 when a shelf dropped on the patient's head. The patient was knocked to the floor. Prior medication history included Vicodin ES and Floricet, and orphenadrone. The patient was treated conservatively with acupuncture which provided her with moderate relief. Diagnostic studies reviewed include CT of the cervical spine dated October 31, 2013 revealed a 1.8 mm central disc protrusion which mildly impresses on the thecal sac at C2-3; a 2.0 mm broad based disc protrusion which mildly impresses on the thecal sac at C3-4. There is a 2.0 mm broad-based disc protrusion which mildly impresses on the thecal sac; mild left facet arthrosis. There is a 3.7 mm right paracentral disc protrusion which moderately impresses on the thecal sac and narrows the entrance to the neural foramina narrowing. On initial ortho consultation dated February 12, 2014, the patient complained of pain in the head and neck. She complained of headaches. She is unable to sleep as she has difficulty with the pain in her right shoulder. On exam, the patient's motor strength is 4/5 in all directions. Her sensation is intact to soft touch with the axillary nerve distribution. She has tenderness over the aspect of the shoulder as well as over the acromioclavicular joint and greater tuberosity. The patient has pain with adduction of the arm across her chest. Her range of motion revealed 160 degrees of forward flexion and abduction; 30 degrees of extension; 20 degrees of adduction; and 50 degrees of internal and external rotation. Diagnosis is right shoulder rotator cuff partial tear. The plan is a local injection, urinalysis, analgesic creams and physical therapy. Prior utilization review dated March 3, 2014 states the request for physical therapy 2x wk x 6wks right shoulder is not authorized as the patient has not responded well to physical therapy in the past and there is no medical necessity for physical therapy after an epidural injection.

IMR ISSUES, DECISIONS AND RATIONALES

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

Physical therapy right shoulder, twice weekly for six weeks: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Guidelines Page(s): 99. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Shoulder, Physical Therapy.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Page(s): 98-99. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) shoulder), Physical therapy.

Decision rationale: According to the Chronic Pain Medical Treatment Guidelines, physical medicine 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. In this case, the patient has already received physical therapy. However, there is no documentation of any improvement in pain or function. Furthermore, the records show that the range of motion is within the normal limits and the patient should have been transferred to home exercise program by now. The records do not show that the prior trial resulted in functional improvement. The request for physical therapy right shoulder, twice weekly for six weeks, is not medically necessary or appropriate.