

Case Number:	CM14-0060802		
Date Assigned:	07/09/2014	Date of Injury:	12/20/2012
Decision Date:	08/08/2014	UR Denial Date:	03/27/2014
Priority:	Standard	Application Received:	05/01/2014

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 75-year-old female who reported an injury on 12/20/2012, due to an unknown mechanism of injury. The injured worker complained of burning, stabbing pain in her right shoulder that radiated down to her elbow. She rated her pain level 5/10. On 03/04/2014, the physical examination revealed limited range of motion in the right shoulder, flexion at 125 degrees, abduction 110 degrees, and internal rotation at 75 degrees. On 08/20/2013, the MRI of the right shoulder revealed no evidence of a rotator cuff tear. There were mild degenerative changes at the right acromioclavicular joint and there is mild lateral down sloping of the acromion. The injured worker had diagnoses of right shoulder subacromial bursitis and right shoulder ankylosis. The past treatment included 1 steroid injection to the right shoulder. A list of the injured worker's current medications was not submitted for review. The current treatment plan is for physical therapy 3 times per week for 4 weeks for the right shoulder. The rationale and request for authorization form were not submitted for review.

IMR ISSUES, DECISIONS AND RATIONALES

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

Physical therapy 3 times per week for 4 weeks for right shoulder: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 2 General Approach to Initial Assessment and Documentation.

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

Decision rationale: The request for physical therapy 3 times per week for 4 weeks for the right shoulder is non-certified. The injured worker has a history of pain to the right shoulder. The California MTUS guidelines state that physical therapy is recommended for Myalgia and myositis, unspecified at a frequency of 9-10 visits over 8 weeks. The request for 12 visits of physical therapy exceeds the guideline recommendations. In addition, there was no documentation showing current objective functional deficits or whether the injured worker has had previous physical therapy. Therefore, the request for physical therapy 3 times per week for 4 weeks for right shoulder is not medically necessary.