MAXIMUS Federal Services

Case Number:	CM14-0193952		
Date Assigned:	12/01/2014	Date of Injury:	03/22/2014
Decision Date:	01/28/2015	UR Denial Date:	11/12/2014
Priority:	Standard	Application Received:	11/19/2014

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 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:

According to the records made available for review, this is a 58-year-old female with a date of injury on 03/22/2014. Documentation from 06/17/2014 indicated that during work hours the injured worker tripped over a bag subsequently injuring the right shoulder. Documentation from 06/17/2014 noted the diagnoses of right shoulder chronic superior labrum anterior and posterior tear with re-injury and possible rotator cuff tear. Subjective findings from 10/20/2014 were remarkable for continued complaints of pain to the affected shoulder. Physical examination from this date was revealing for bilateral shoulder range of motion of 170 degrees at elevation, 170 degrees at abduction, 70 degrees at external rotation, and internal rotation on the right side to the lumbar spine and the left side to the thoracic spine. Tenderness was also noted on palpation in the bicipital groove and over the acromioclavicular joint on the right side. The strength at the rotator cuff bilaterally was a five out of five, but with significant pain with strength testing on the right side of the supraspinatus and infraspinatus. Documentation from 10/20/2014 noted magnetic resonance imaging performed on 07/21/2014 that was remarkable for partial tearing of the supraspinatus tendon, a ninety percent thickness tear of the supraspinatus and infraspinatus, moderate acromioclavicular joint arthrosis with spurring, grade three to four chondral loss at the articular superior humeral head, subchondral cystic changes of the greater tuberosity, healed bony Bankart fracture with grade three chondral changes, and tendinosis of the biceps tendon in the superior labrum anterior and posterior tear. X-ray from 10/20/2014 noted the humeral head to be slightly high riding within the glenoid, osseous cysts were noted at the greater tuberosity at the insertion of the rotator cuff, and a Type II acromion. Prior treatments offered to the injured worker included cortisone injection and physical therapy of an unknown amount. Medical records from 10/20/2014 noted a work status of remain off work. On 11/12/2014, Utilization Review non-certified the prescription of additional physical therapy visits times twelve for the

right shoulder. The physical therapy was noncertified based on CA MTUS Chronic Pain Medical Treatment Guidelines, Physical Medicine, noting up to three visits a week to one or less approved along with a self-home physical program and Official Disability Guidelines noted approved physical therapy for up to eight weeks after an injury, but it not indicated for chronic pain. Utilization Review noted that the injured worker was previously approved for twelve session of physical therapy with no documentation with regards to functional improvement.

IMR ISSUES, DECISIONS AND RATIONALES

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

Twelve sessions of additional Physical Therapy visits for the right shoulder: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine. 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 section. Page(s): 98, 99.

Decision rationale: The MTUS Guidelines recommend physical therapy focused on active therapy to restore flexibility, strength, endurance, function, range of motion and alleviate discomfort. The MTUS Guidelines support physical therapy that is providing a documented benefit. Physical therapy should be provided at a decreasing frequency (from up to 3 visits per week to 1 or less) as the guided therapy becomes replaced by a self-directed home exercise program. The physical medicine guidelines recommend myalgia and myositis, unspecified; receive 9-10 visits over 8 weeks. While documentation indicated a prior physical therapy treatment was provided, there was no documentation of quantity, treatment plan, or results of prior physical therapy visits. The medical records provided did not note specific details of functional improvement, improvement in work function, or in activities of daily living. Utilization review dated 11/12/2014 indicates that the injured worker has had 12 sessions of physical therapy. The status of a home exercise program is not reported. It would be expected, however, that following 12 sessions of physical therapy the injured worker would have a home exercise program established for continued self-directed therapy. Medical necessity of this request has not been established within the recommendations of the MTUS Guidelines. The request for twelve sessions of additional Physical Therapy Visits for the right shoulder is not medically necessary.