

Case Number:	CM14-0195589		
Date Assigned:	12/03/2014	Date of Injury:	10/29/2013
Decision Date:	01/20/2015	UR Denial Date:	11/04/2014
Priority:	Standard	Application Received:	11/21/2014

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 Connecticut. 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 68-year-old female who reported an injury on 10/29/2013 due to an unspecified mechanism of injury. Her diagnoses include a rotator cuff tear and cervical spine pain. Her past treatments included medication, surgery, and physical therapy. On 10/17/2014, the injured worker had a followup regarding her right shoulder pain. She also indicated some neck pain with radicular symptoms down to the right upper extremity. The physical examination of the right shoulder revealed tenderness over the AC joint and bicipital groove region. The shoulder range of motion was indicated to be abduction 85 degrees, forward flexion at 80 degrees, external rotation at 60 degrees, and internal rotation at 60 degrees. The documentation indicated the injured worker had full passive range of motion. She also showed some discomfort with the Speed's test, empty can test, and the O'Brien's test. The injured worker was indicated to have a positive impingement sign with the Neer's test and Hawkins tests. Her medications included ibuprofen, hydrocodone, and Menthoderm gel for her shoulder. The dosages and frequencies were not provided. The treatment plan was for [REDACTED] physical therapy, 2-3 times weekly, right shoulder, QTY: 21.00. The rationale was to increase her range of motion through therapy and decrease her pain level. A Request for Authorization form was submitted on 10/17/2014 for review.

IMR ISSUES, DECISIONS AND RATIONALES

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

[REDACTED] physical therapy, 2-3 times weekly, right shoulder QTY: 21.00: Upheld

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

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

Decision rationale: The request for [REDACTED] physical therapy, 2-3 times weekly, right shoulder, QTY: 21.00 are not medically necessary. According to the California MTUS Guidelines, physical therapy may be warranted for neuralgia, neuritis, and radiculitis for up to 8 to 10 visits. Furthermore, therapeutic exercises and/or activities are beneficial for restoring flexibility, strength, endurance, function, range of motion, and to assist alleviate discomfort. The injured worker is indicated to have right shoulder pain with a full thickness rotator cuff tear with a possible subscapularis tear. The documentation indicated the injured worker had decreased strength, decreased right shoulder range of motion, and decreased cervical range of motion. The physical examination findings would warrant physical therapy for the injured worker; however, case notes already indicate that the injured worker was authorized [REDACTED] physical therapy 2 times a week for 4 weeks as suggested by the guidelines. In addition, the request fails to indicate duration for the request. Based on the above, the request is not supported by the evidence based guidelines. As such, the request is not medically necessary.