

Case Number:	CM14-0212802		
Date Assigned:	12/30/2014	Date of Injury:	02/02/2004
Decision Date:	05/04/2015	UR Denial Date:	12/01/2014
Priority:	Standard	Application Received:	12/19/2014

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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:

State(s) of Licensure: Massachusetts

Certification(s)/Specialty: Physical Medicine & Rehabilitation, Pain Management

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 73 year old female, who sustained an industrial injury on 2/2/04. She reported bilateral shoulder and bilateral hand pain with limitations. The injured worker was diagnosed as having status post right shoulder arthroscopic decompression for rotator cuff impingement and partial rotator cuff tear. Other diagnoses included bilateral hand tendinitis and strain symptoms. Treatment to date has included medications and home exercise. The injured worker underwent a right shoulder cuff repair on 4/4/06. Currently, the injured worker complains of right shoulder pain. The treating physician requested authorization for physical therapy 2x6 for the left wrist, purchase of a foam roller for the right shoulder, and 1 cortisone injection for the right shoulder. No rationale for the requests was noted in the documentation provided.

IMR ISSUES, DECISIONS AND RATIONALES

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

Physical Therapy 2 x6 to the left wrist: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints, Chronic Pain Treatment Guidelines Physical Medicine. Decision based on Non-MTUS Citation Official Disability Guidelines.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) (1) Chronic pain, Physical medicine treatment. (2) Preface, Physical Therapy Guidelines.

Decision rationale: The claimant is more than 10 years status post work-related injury and continues to be treated for right shoulder and bilateral hand pain. Treatments have included a right rotator cuff repair in 2006. When seen, there was right shoulder impingement. There was decreased active range of motion. She had numbness and tingling of the fingers and hands. In terms of physical therapy treatment for chronic pain, guidelines recommend a six visit clinical trial with a formal reassessment prior to continuing therapy. In this case, the number of visits requested is in excess of that recommended and therefore not medically necessary.

Foam roller for purchase for the right shoulder: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines- Knee & Leg-Durable Medical Equipment (DME).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical medicine, p98-99 Page(s): 98-99.

Decision rationale: The claimant is more than 10 years status post work-related injury and continues to be treated for right shoulder and bilateral hand pain. Treatments have included a right rotator cuff repair in 2006. When seen, there was right shoulder impingement. There was decreased active range of motion. She had numbness and tingling of the fingers and hands. The claimant has already had therapy treatments. Compliance with a home exercise program would be expected would not required specialized equipment. Therefore the requested foam roller was not medically necessary.

Cortisone injection x1 to the right shoulder: Overturned

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 201-205.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder (Acute & Chronic), Steroid injections.

Decision rationale: The claimant is more than 10 years status post work-related injury and continues to be treated for right shoulder and bilateral hand pain. Treatments have included a right rotator cuff repair in 2006. When seen, there was right shoulder impingement. There was decreased active range of motion. She had numbness and tingling of the fingers and hands. A steroid injection is recommended as an option which shoulder pain is not controlled adequately by recommended conservative treatments including physical therapy, exercise, and medications after at least 3 months. In this case, the claimant has had conservative treatments and continues to have symptoms. She has a history of shoulder surgery with physical examination findings

consistent with rotator cuff impingement which would support performing the requested injection. Therefore the it is medically necessary.