

Case Number:	CM15-0102585		
Date Assigned:	06/05/2015	Date of Injury:	02/06/2015
Decision Date:	08/20/2015	UR Denial Date:	05/18/2015
Priority:	Standard	Application Received:	05/28/2015

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: California

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 49 year old female, who sustained an industrial injury on 2/6/15. Initial complaints were of her left upper arm and shoulder extending up the left side of her neck pain. The injured worker was diagnosed as having left acromioclavicular osteoarthritis. Treatment to date has included physical therapy; medications. Diagnostics studies included X-rays left shoulder (4/21/15); EMG/NCV study lower extremities (3/16/15). Currently, the PR-2 notes dated 4/21/15 indicated the injured worker present today for a follow-up of her left shoulder pain. She is relatively unchanged since her last visit. She continues to await authorization for physical therapy for her left shoulder. She complains of throbbing and burning pain over the top of the shoulder with pain radiating into the left side of her neck and upper back and down the left arm to the elbow and sometimes her left hand goes numb. She is currently rating her pain as 9/10. Her pain symptoms increase with repetitive motion such as mopping, sweeping, and other cleaning duties. Additionally, quick motion of the arm overhead causes her arm to "become stuck". Her pain is alleviated with rest and medications. She denies physical therapy, injections, MRI's or x-rays have been done to date. She did a trial of Ketoprofen cream which provides some temporary relief. Orthopedic examination is documented for the left shoulder noting forward flexion to about 110 degrees, abduction to about 90 degrees. She has full strength of her rotator cuff, supraspinatus, infraspinatus, subscapularis, and teres minor. She has a positive Neer's impingement test, and a negative drop can and apprehension and sulcus sign. X-rays of her left shoulder were 4 views on this date and revealed left acromial joint osteoarthritis. A report of an EMG/NCV study of the bilateral lower extremities was done due to the injured

workers low back pain radiating to the lower left extremity. The impression notes an abnormal study revealing right S1 radiculopathy and no evidence of focal nerve entrapment or generalized peripheral neuropathy affecting the lower limbs. The provider is requesting authorization of physical therapy 2 times a week for 6 weeks for the left shoulder 12 sessions.

IMR ISSUES, DECISIONS AND RATIONALES

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

Physical Therapy 2xWk x 6Wks for the left shoulder, QTY: 12: Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 200. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder Chapter, Physical Therapy.

Decision rationale: Regarding the request for physical therapy, Chronic Pain Medical Treatment Guidelines recommend a short course of active therapy with continuation of active therapies at home as an extension of the treatment process in order to maintain improvement levels. ODG has more specific criteria for the ongoing use of physical therapy. ODG recommends a trial of physical therapy. If the trial of physical therapy results in objective functional improvement, as well as ongoing objective treatment goals, then additional therapy may be considered. Within the documentation available for review, it does not appear the patient has undergone physical therapy previously. Guidelines support the use of a 6-visit trial a therapy with further therapy being supported based upon documentation of objective functional improvement and ongoing treatment goals. Unfortunately, the currently requested 12-visit exceeds the 6-visit trial supported by guidelines, and there is no provision to modify the current request. As such, the current request for physical therapy is not medically necessary.