

Case Number:	CM15-0104088		
Date Assigned:	06/11/2015	Date of Injury:	02/03/2014
Decision Date:	07/16/2015	UR Denial Date:	05/15/2015
Priority:	Standard	Application Received:	05/30/2015

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

CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

This 66 year old female sustained an industrial injury on 2/3/14. She subsequently reported left shoulder pain. Diagnoses include osteoarthritis. Treatments to date include therapy, injections, work restrictions and prescription pain medications. The injured worker continues to experience left shoulder pain. Upon examination, left shoulder range of motion was restricted. There was positive pain and crepitus with forward flexion, abduction and external rotation. Jobe's and O'Brien's signs were positive. A request for Physical Therapy evaluation, left shoulder, Therapeutic exercises for the left shoulder, twice weekly for six weeks and Manual Therapy techniques for the left shoulder, twice a week for six weeks was made by the treating physician.

IMR ISSUES, DECISIONS AND RATIONALES

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

Physical Therapy evaluation, left shoulder: Overturned

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

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

Decision rationale: The patient presents with left shoulder pain rated 8-9/10. The request is for PHYSICAL THERAPY EVALUATION, LEFT SHOULDER. The request for authorization is not provided. MRI of the left shoulder, date unspecified, shows moderate to severe osteoarthritic changes in the glenohumeral joint, as well as mild to moderate rotator cuff tendinopathy and partial tear. Physical examination of the left shoulder reveals limited range of motion with positive pain and crepitus. She has positive Jobe's with pain and positive O'Brien's. She has difficulty with activities of daily living such as putting on her bra or reaching behind her back. She has tried physical therapy in the past with no improvement. She also had a cortisone injection that helped for a limited time. Per progress report dated 06/24/14, the patient is working modified duty. MTUS Chronic Pain Management Guidelines, pages 98,99 has the following: "Physical Medicine: recommended as indicated below. Allow for fading of treatment frequency (from up to 3 visits per week to 1 or less), plus active self-directed home Physical Medicine." MTUS guidelines pages 98, 99 states that for "Myalgia and myositis, 9-10 visits are recommended over 8 weeks. For Neuralgia, neuritis, and radiculitis, 8-10 visits are recommended." Per progress report dated 04/23/15, treater's reason for the request is "to see if we can optimize her range of motion and functional status." In this case, the patient has tried physical therapy in the past with no improvement. However, given the patient continues with severe left shoulder pain, a physical therapy evaluation would be indicated. Physical therapy treatment history or reports is not provided to determine how many previous sessions the patient has had. Therefore, the request IS medically necessary.

Therapeutic exercises for the left shoulder, twice weekly for six weeks: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official disability guidelines Pain (Chronic) Chapter, Exercise.

Decision rationale: The patient presents with left shoulder pain rated 8-9/10. The request is for THERAPEUTIC EXERCISES FOR THE LEFT SHOULDER, TWICE WEEKLY FOR SIX WEEKS. The request for authorization is not provided. MRI of the left shoulder, date unspecified, shows moderate to severe osteoarthritic changes in the glenohumeral joint, as well as mild to moderate rotator cuff tendinopathy and partial tear. Physical examination of the left shoulder reveals limited range of motion with positive pain and crepitus. She has positive Jobe's with pain and positive O'Brien's. She has difficulty with activities of daily living such as putting on her bra or reaching behind her back. She has tried physical therapy in the past with no improvement. She also had a cortisone injection that helped for a limited time. Per progress report dated 06/24/14, the patient is working modified duty. ODG-TWC, Pain (Chronic) Chapter under Exercise states: "Recommended. There is strong evidence that exercise programs, including aerobic conditioning and strengthening, are superior to treatment programs that do not include exercise. There is no sufficient evidence to support the recommendation of any particular exercise regimen over any other exercise regimen. A therapeutic exercise program should be initiated at the start of any treatment or rehabilitation program, unless exercise is contraindicated.

Such programs should emphasize education, independence, and the importance of an on-going exercise regime. (State, 2002) Treater does not discuss the request. In this case, ODG supports the treatment of therapeutic exercises. However, treater does not explain how and what is to be done. And there is no explanation as to why the therapeutic exercises cannot be performed at home and why a therapist or professional intervention is needed. Therefore, the request IS NOT medically necessary.

Manual Therapy techniques for the left shoulder, twice a week for six weeks: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Manual therapy Page(s): 58-59.

Decision rationale: The patient presents with left shoulder pain rated 8-9/10. The request is for MANUAL THERAPY TECHNIQUES FOR THE LEFT SHOULDER, TWICE A WEEK FOR SIX WEEKS. The request for authorization is not provided. MRI of the left shoulder, date unspecified, shows moderate to severe osteoarthritic changes in the glenohumeral joint, as well as mild to moderate rotator cuff tendinopathy and partial tear. Physical examination of the left shoulder reveals limited range of motion with positive pain and crepitus. She has positive Jobe's with pain and positive O'Brien's. She has difficulty with activities of daily living such as putting on her bra or reaching behind her back. She has tried physical therapy in the past with no improvement. She also had a cortisone injection that helped for a limited time. Per progress report dated 06/24/14, the patient is working modified duty. MTUS recommends an optional trial of 6 visits over 2 weeks with evidence of objective functional improvement total of up to 18 visits over 6 to 8 weeks. For recurrences/flare-ups, reevaluate treatment success and if return to work is achieved, then 1 to 2 visits every 4 to 6 months. MTUS page 8 also requires that the treater monitor the treatment progress to determine appropriate course of treatments. For manual therapy, the MTUS guidelines on page 59 states, "██████ recommendations in effect incorporate two trials, with a total of up to 12 trial visits with a re-evaluation in the middle, before also continuing up to 12 more visits (for a total of up to 24)." Treater does not discuss the request. Treatment history is not provided and there is no mention patient has had manual therapy in the past. In this case, given the patient's condition, an initial trial of 6 visits would be reasonable. However, the request for 12 initial sessions of manual therapy would exceed MTUS guidelines. Therefore, the request IS NOT medically necessary.