

Case Number:	CM15-0130002		
Date Assigned:	07/17/2015	Date of Injury:	01/23/2009
Decision Date:	08/12/2015	UR Denial Date:	06/25/2015
Priority:	Standard	Application Received:	07/06/2015

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: New Jersey, Alabama, California

Certification(s)/Specialty: Neurology, Neuromuscular Medicine

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 was a 47 year old female, who sustained an industrial injury, January 23, 2009. The injured worker previously received the following treatments bilateral S1 joint injection, physical therapy for the left shoulder and neck, Tramadol, capsaicin cream, pantoprazole, Cyclobenzaprine, Naproxen, Fexofenadine, home exercise program and MRI of the right shoulder which showed an irregular posterior labral tear, paralabral cyst along the posterior superior of the glenoid. Mild subdeltoid bursitis, mild distal supraspinatus tendinopathy, possible small interstitial tears along the anterior margin of the glenohumeral degenerative changes, there was subcortical cystic degeneration of the lesser tubercle at the subscapularis insertion. The injured worker was diagnosed with lumbar disc displacement without myelopathy, pain in joint shoulders, chronic pain, and chronic pain syndrome. According to progress note of March 18, 2015, the injured worker's chief complaint was stiffness and loss of motion in the neck. There was pain radiating from the neck into the bilateral trapezii muscles, shoulder blades and down both the upper limbs, with intermittent pain into the fingers. The same was true on the left and right. The injured worker was still having numbness, weakness and tingling in both upper limbs. When lifting, carrying, pushing or pulling hurts in the left arm, but not the right. The injured worker was able to comb hair, brush teeth, drive, dress herself write and use the computer. The range of motion was much better with the right than the left. The injured worker was having trouble sleeping at night due to the pain. The range of motion of the right shoulder was abduction 180 out 180, flexion was 180 out of 180, internal rotation was 90 out of 90, external rotation was 100 out of 90 and the right elbow extension was 65 out of 50 and adduction was 60 out of 50. The treatment plan included addition physical therapy for the right shoulder.

IMR ISSUES, DECISIONS AND RATIONALES

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

Additional physical therapy right shoulder Qty 6: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical medicine.

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

Decision rationale: According to MTUS guidelines, Physical Medicine is "Recommended as indicated below. Passive therapy (those treatment modalities that do not require energy expenditure on the part of the patient) can provide short term relief during the early phases of pain treatment and are directed at controlling symptoms such as pain, inflammation and swelling and to improve the rate of healing soft tissue injuries. They can be used sparingly with active therapies to help control swelling, pain and inflammation during the rehabilitation process. Active therapy is based on the philosophy that therapeutic exercise and/or activity are beneficial for restoring flexibility, strength, endurance, function, range of motion, and can alleviate discomfort. Active therapy requires an internal effort by the individual to complete a specific exercise or task. This form of therapy may require supervision from a therapist or medical provider such as verbal, visual and/or tactile instruction(s). Patients are instructed and expected to continue active therapies at home as an extension of the treatment process in order to maintain improvement levels. Home exercise can include exercise with or without mechanical assistance or resistance and functional activities with assistive devices. (Colorado, 2002) (Airaksinen, 2006) Patient-specific hand therapy is very important in reducing swelling, decreasing pain, and improving range of motion in CRPS. (Li, 2005) The use of active treatment modalities (e.g., exercise, education, activity modification) instead of passive treatments is associated with substantially better clinical outcomes. In a large case series of patients with low back pain treated by physical therapists, those adhering to guidelines for active rather than passive treatments incurred fewer treatment visits, cost less, and had less pain and less disability. The overall success rates were 64.7% among those adhering to the active treatment recommendations versus 36.5% for passive treatment. (Fritz, 2007)." The patient underwent at least 18 sessions of physical therapy without clear documentation of efficacy. There is no documentation that the patient cannot perform home exercise. Therefore, 6 additional physical therapy sessions for the right shoulder is not medically necessary.