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| Case Number: | CM15-0130339 | | |
| Date Assigned: | 07/16/2015 | Date of Injury: | 01/04/2010 |
| Decision Date: | 08/12/2015 | UR Denial Date: | 06/11/2015 |
| 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: 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 55 year old male, who sustained an industrial injury on 1/4/2010. Diagnoses have included unspecified disorders of bursae and tendons in the shoulder region. Treatment to date has included shoulder surgery and medication. According to the progress report dated 6/4/2015, the injured worker complained of left shoulder pain. Exam of the shoulder and upper arm revealed tenderness to palpation and decreased strength. The injured worker was given a steroid injection to the left shoulder. Authorization was requested for physical therapy for the left shoulder.

IMR ISSUES, DECISIONS AND RATIONALES

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

Physical therapy, left shoulder Qty: 12: Upheld

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

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) Physical therapy.

Decision rationale: The claimant sustained a work injury in January 2010 and continues to be treated for left shoulder pain. He underwent a left shoulder arthroscopic subacromial decompression 2010. He had done well but was having symptoms after recent right shoulder surgery. When seen, there was decreased and painful shoulder range of motion with supraspinatus tenderness impingement testing with positive. There was decreased left shoulder strength. A subacromial injection was performed and he was referred for physical therapy. Eight sessions of physical therapy for the left shoulder was requested. Guidelines recommend up to 10 physical therapy sessions over 8 weeks for the treatment of rotator cuff impingement syndrome. In this case, the claimant has already had physical therapy. The number of treatments being requested is in excess of the guideline recommendation or what would be expected to be needed to reestablish or revise his home exercise program. The request is not medically necessary.