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| Case Number: | CM15-0138597 | | |
| Date Assigned: | 07/28/2015 | Date of Injury: | 11/15/2011 |
| Decision Date: | 09/11/2015 | UR Denial Date: | 06/30/2015 |
| Priority: | Standard | Application Received: | 07/17/2015 |

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: Iowa, Illinois, Hawaii

Certification(s)/Specialty: Preventive Medicine, Occupational Medicine, Public Health & General Preventive 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 is a 45 year old female, who sustained an industrial injury on November 15, 2011. She reported an injury to her right shoulder due to continuous trauma. She reported neck pain, elbow pain and numbness in the hand. Treatment to date has included diagnostic imaging, hand surgery, opioid medications, and work restrictions. Currently, the injured worker complains of right shoulder pain located in the deltoid area. She uses Norco each day to relieve the pain. Her pain is aggravated by reaching, lifting, repetitive use, cooking and cleaning. On physical examination the injured worker has tenderness to palpation over the right acromioclavicular joint. Her right shoulder range of motion is 180-90-80 and she has pain and weakness with abduction and external rotation. She has positive impingement sign. An x-ray of the right shoulder reveals a type II acromion with an eyebrow sign and acromioclavicular joint arthritis. She has supraspinatus tendinosis with moderate articular surface tear, bursitis and acromioclavicular joint arthritis. The diagnosis associated with the request is right rotator cuff impingement and acromioclavicular joint arthrosis. The treatment plan includes physical therapy for home exercise program instructions, Motrin, ice therapy, discontinuation of Norco and acromioclavicular joint injections.

IMR ISSUES, DECISIONS AND RATIONALES

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

Physical therapy 12 visits for the right shoulder: Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 196-219, Chronic Pain Treatment Guidelines Physical Therapy, Physical Medicine Page(s): 98-99. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder (Acute & Chronic), Physical therapy.

Decision rationale: California MTUS guidelines refer to physical medicine guidelines for physical therapy. "Allow for fading of treatment frequency (from up to 3 visits per week to 1 or less), plus active self-directed home Physical Medicine." Additionally, ACOEM guidelines advise against passive modalities by a therapist unless exercises are to be carried out at home by patient. Additionally sessions may be warranted based on the progress during the initial treatment sessions. Regarding physical therapy, ODG states "Patients should be formally assessed after a "six-visit clinical trial" to see if the patient is moving in a positive direction, no direction, or a negative direction (prior to continuing with the physical therapy); & (6) When treatment duration and/or number of visits exceeds the guideline, exceptional factors should be noted." At the conclusion of this trial, additional treatment would be assessed based upon documented objective, functional improvement, and appropriate goals for the additional treatment. Additionally, ODG states "Sprained shoulder; rotator cuff (ICD9 840; 840.4): Medical treatment: 10 visits over 8 weeks. Medical treatment, partial tear: 20 visits over 10 weeks. Post- surgical treatment (RC repair/acromioplasty): 24 visits over 14 weeks". The medical documentation provided indicate this patient has had an unknown number of physical therapy sessions. The treating physician has not provided documentation of objective functional improvement from this therapy to warrant additional sessions. As such, the request for Physical therapy 12 visits for the right shoulder is not medically necessary.