

Case Number:	CM15-0141785		
Date Assigned:	07/31/2015	Date of Injury:	10/02/2014
Decision Date:	08/28/2015	UR Denial Date:	06/16/2015
Priority:	Standard	Application Received:	07/21/2015

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 56-year-old male who sustained an industrial injury on October 2, 2014 resulting in right shoulder pain including impaired movement. He was diagnosed with shoulder sprain or strain, right shoulder tendonitis, and right shoulder bursitis. Treatment has included physical therapy, shockwave therapy, chiropractic therapy, and medication with no noted improvement documented. The injured worker continues to present with right shoulder pain, swelling, and impaired range of motion. The treating physician's plan of care includes a hot-cold therapy unit and 12 physical therapy sessions for the right shoulder. As of July 12, 2015, his work status was to remain off work.

IMR ISSUES, DECISIONS AND RATIONALES

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

Hot/Cold Therapy Unit: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Shoulder-Continuous-flow cryotherapy.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder Chapter, Continuous-flow cryotherapy section.

Decision rationale: Regarding the request for Hot/Cold Therapy Unit: CA MTUS does not address the issue. ODG cites that continuous-flow cryotherapy is recommended as an option after surgery for up to 7 days, including home use, but not for non-surgical treatment. Within the documentation available for review, it does not appear that the request is for postoperative use. Regardless, there is no support for use of the unit for more than 7 days and, unfortunately, there is no provision for modification of the current request. As such, the currently requested Hot/Cold Therapy Unit is not medically necessary.

12 physical therapy sessions for the right shoulder: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines 8 C.C.R. 9792.20-9792.26 MTUS (Effective July 18, 2009) Page(s): 98-99 of 127. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder Chapter, Physical Medicine.

Decision rationale: Regarding the request for physical therapy, Chronic Pain Medical Treatment Guidelines recommend a short course (10 sessions) 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, there is no documentation of specific objective functional improvement with any previous sessions and remaining deficits that cannot be addressed within the context of an independent home exercise program yet are expected to improve with formal supervised therapy. Furthermore, the request exceeds the amount of PT recommended by the CA MTUS and, unfortunately, there is no provision for modification of the current request. In light of the above issues, the currently requested physical therapy is not medically necessary.