

Case Number:	CM15-0182452		
Date Assigned:	09/23/2015	Date of Injury:	04/01/2001
Decision Date:	10/28/2015	UR Denial Date:	09/16/2015
Priority:	Standard	Application Received:	09/16/2015

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 49 year old female who sustained an industrial injury on 4-1-2001. A review of medical records indicated the injured worker is being treated for shoulder impingement, tendinitis, pain in soft tissues of limb, enthesopathy of unspecified site, and chronic pain. Medical records dated 8-26-2015 noted pain to bilateral shoulder and point tenderness over the right superior angle of the scapula. Physical examination noted no significant clinical change to shoulder and lower extremities. Medical records dated 9-15-2015 revealed rotation of the cervical spine was limited to 4 degrees right and left with pain. Range of motion of both shoulders revealed abduction of 45 degrees with pain, extension was 5 degrees with pain, and flexion of 40 degrees with pain. The injured worker was noted as permanent and stationary. Treatment has included tramadol, Naprosyn, 6 psychology visits, and 6 sessions of chiropractic treatment. MRI of both shoulders dated 12-15-2009 revealed no rotator cuff tear although some evidence of tendinopathy and tendinitis was noted. RFA dated 9-15-2015 requested physical therapy for the right shoulder 2 times a week for 6 weeks. Utilization review form dated 9-16-2015 modified 12 physical therapy for the right shoulder 2 times a week for 6 weeks.

IMR ISSUES, DECISIONS AND RATIONALES

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

12 Physical therapy for the right shoulder (2 x 6): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) (1) Chronic pain, Physical medicine treatment. (2) Preface, Physical Therapy Guidelines (3) Shoulder (Acute & Chronic), physical therapy.

Decision rationale: The claimant has a remote history of a work injury in April 2001 and is being treated for right shoulder pain. When seen, she was having increasing symptoms at the right scapular superior angle consistent with her prescribed of rotator cuff tendinitis. Physical examination findings include a body mass index over 37. Authorization for 12 physical therapy treatments is being requested. In terms of physical therapy for rotator cuff impingement syndrome, guidelines recommend up to 10 treatment sessions over 8 weeks. However, the claimant is being treated for chronic pain with no new injury. In terms of physical therapy treatment for chronic pain, guidelines recommend a six visit clinical trial with a formal reassessment prior to continuing therapy. In this case, the number of visits requested is in excess of that recommended for either an acute injury or a chronic condition and what might be needed to determine whether continuation of physical therapy was needed or likely to be effective. The request is not medically necessary.