MAXIMUS Federal Services

Case Number:	CM15-0184503		
Date Assigned:	09/25/2015	Date of Injury:	03/31/2009
Decision Date:	10/30/2015	UR Denial Date:	08/27/2015
Priority:	Standard	Application Received:	09/19/2015

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 52 year old female, who sustained an industrial injury on 3-31-09. The injured worker is undergoing treatment for pain in joint shoulder, psychogenic pain, chronic pain syndrome and long-term use of medication. Medical records dated 8-10-15 indicates the injured worker complains of persistent shoulder pain. She reports medication provides 30% pain decrease, and acupuncture "decreased her overall level of pain from a 7-8 out of 10 VAS scale to a 5 out of 10." An office visit dated 7-13-15 indicates 30% pain reduction with medication. Physical exam dated 8-10-15 notes positive impingement and Speeds test, limited range of motion (ROM) and tenderness to palpation of the left shoulder. Treatment to date has included right shoulder surgery, left shoulder cortisone injection with 5 months pain relief, functional restoration program, acupuncture X 6 and medication. The original utilization review dated 8-27- 15 indicates the request for physical therapy 2 X 3 to the left shoulder is non-certified.

IMR ISSUES, DECISIONS AND RATIONALES

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

Physical therapy 2 times a week for 3 weeks to the left shoulder: Overturned

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.

Decision rationale: The claimant sustained a work injury in March 2009 when she tripped and fell onto her right side. She had full thickness rotator cuff tear and underwent arthroscopic surgery in June 2009 with revision surgery in July 2012. When seen, she was having chronic bilateral shoulder pain. There had been recent completion of six sessions of acupuncture. Physical examination findings included moderate obesity. There was decreased shoulder range of motion with positive impingement testing. There was acromioclavicular joint tenderness with positive cross arm tests. Authorization for a subacromial injection and six sessions of physical therapy was requested. The claimant is being treated for chronic pain and has not had physical therapy in at least 6 months. 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 consistent with that recommended and what might be anticipated in terms of establishing or revising a home exercise program or determining whether additional physical therapy was needed or likely to be effective. The claimant has ongoing impairments. The request is medically necessary.