

Case Number:	CM15-0187298		
Date Assigned:	09/29/2015	Date of Injury:	08/26/2009
Decision Date:	11/06/2015	UR Denial Date:	08/25/2015
Priority:	Standard	Application Received:	09/23/2015

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

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 47 year old male who sustained an industrial injury on 08-26-2009. A review of the medical records indicated that the injured worker is undergoing treatment for right shoulder impingement with small partial articular rotator cuff tear. The injured worker has a medical history of hypertension, diabetes mellitus, and gastroesophageal reflux disorder (GERD) and peptic ulcer secondary to anti-inflammatory medications. According to the treating physician's progress report on 08-05-2015, the injured worker reported intermittent slight to moderate right shoulder pain aggravated with heavy lifting, reaching and pushing. Examination of the right shoulder demonstrated no atrophy of the right parascapular, supraspinatus or infraspinatus muscles. The left shoulder documented atrophy of the entire shoulder musculature without atrophy to the left upper extremity. Range of motion was equally decreased bilaterally with negative instability of the glenohumeral joint and a negative labrum examination. Rotator cuff evaluation demonstrated positive Neer's, Hawkins and Jobe's impingement tests on the right shoulder and negative on the left. Biceps tendon tests were negative bilaterally. There was mild tenderness at the acromioclavicular joint with positive anterior and posterior acromioclavicular joint stress tests. Motor strength was decreased at abduction and extension rotation bilaterally. Sensation and deep tendon reflexes were within normal limits bilaterally. A recent diagnostic test of a right shoulder magnetic resonance imaging (MRI) on 04-30-2015 with official report was included in the review. On 08-11-2015 the injured worker received a right shoulder subacromial cortisone injection with improvement and decreased "inflamed feeling" and no radiation noted on the progress report dated 08-13-2015. The injured worker rated his pain after

the shoulder injection at 3 out of 10 on the pain scale. Prior treatments have included diagnostic testing, work conditioning, shoulder injection and medications. Current medications were listed as Ambien, Xanax and Wellbutrin. Treatment plan consists of orthopedic consultation for right shoulder and the current request for physical therapy 3 times a week for 6 weeks for the right shoulder. The Utilization Review modified the request for physical therapy 3 times a week for 6 weeks for the right shoulder to physical therapy twice a week for 4 weeks for the right shoulder on 08-25-2015.

IMR ISSUES, DECISIONS AND RATIONALES

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

Physical therapy 3 times a week for 6 weeks for the right shoulder: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Physical Medicine.

Decision rationale: Review indicates the request for PT was modified for 8 sessions. Time-limited care plan with specific defined goals, assessment of functional benefit with modification of ongoing treatment based upon the patient's progress in meeting those goals and the provider's continued monitoring of successful outcome is stressed by MTUS guidelines. Therapy is considered medically necessary when the services require the judgment, knowledge, and skills of a qualified physical therapist due to the complexity and sophistication of the therapy and the physical condition of the patient. Submitted reports have no acute flare-up or specific physical limitations to support for physical/occupational therapy. The Chronic Pain Guidelines allow for 9-10 visits of therapy with fading of treatment to an independent self-directed home program. It is unclear how many PT sessions have been completed; however, the submitted reports have not identified clear specific functional improvement in ADLs, functional status, or decrease in medication and medical utilization nor have there been a change in neurological compromise or red-flag findings demonstrated from the formal physical therapy already rendered to support further treatment. Submitted reports have also not adequately demonstrated the indication to support for excessive quantity of PT sessions without extenuating circumstances established beyond the guidelines. The Physical therapy 3 times a week for 6 weeks for the right shoulder is not medically necessary and appropriate.