

Case Number:	CM15-0190250		
Date Assigned:	10/02/2015	Date of Injury:	04/04/1995
Decision Date:	11/13/2015	UR Denial Date:	08/28/2015
Priority:	Standard	Application Received:	09/28/2015

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, California

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 59 year old female who sustained an industrial injury April 4, 1995. Past history included status post right arthroscopic surgery x (2) hypertension, diabetes mellitus, and hyperlipidemia. According to an orthopedic consultation dated July 30, 2015, the injured worker presented with complaints of pain in the superolateral aspect of her shoulder. Physical examination revealed 5'5" and 200 pounds; right shoulder- tenderness to palpation diffusely and anteriorly; range of motion she can elevate her arm 170 degrees, externally rotate 70 degrees and internally rotate to T7 all with pain; negative belly press test; pain with Neer's and Hawkins impingement sign. Diagnostic impression; lifting injury right shoulder; status two prior right shoulder arthroscopy surgeries; right shoulder pain. At issue, is the request for authorization dated July 30, 2015, for physical therapy (12) sessions and an x-ray of the right shoulder. According to utilization review dated August 28, 2015, the request for (12) physical therapy sessions was modified to physical therapy for (6) sessions. The request for x-ray of the right shoulder is non-certified.

IMR ISSUES, DECISIONS AND RATIONALES

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

X-ray of the right shoulder X 1: Upheld

Claims Administrator guideline: Decision based on MTUS Shoulder Complaints 2004. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Shoulder (Acute & Chronic): Radiography.

MAXIMUS guideline: Decision based on MTUS Shoulder Complaints 2004, Section(s): Special Studies. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder, Radiography.

Decision rationale: ACOEM states "for acute AC joint separations, stress films (views of both shoulders, with and without patient holding weights) (D). D Panel interpretation of information not meeting inclusion criteria for research-based evidence." ODG States Indications for imaging. Plain radiographs: Acute shoulder trauma, rule out fracture or dislocation. Acute shoulder trauma, questionable bursitis, blood calcium (Ca+)/approximately 3 months duration, first study. The treating physician has not documented a history of acute shoulder trauma, questionable bursitis or blood calcium level concerns as outlined above. As such, the request for an X-ray of the right shoulder X 1 is not medically necessary.

Physical therapy 12 sessions: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Shoulder (Acute & Chronic): Physical Therapy Guidelines.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Physical Medicine. Decision based on Non-MTUS Citation Shoulder (Acute & Chronic), Physical Therapy, ODG Preface - 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." 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. The request for 12 sessions is far in excess of the initial trials per MTUS and ODG guidelines. As such, the request for Physical therapy 12 sessions is not medically necessary.