

Case Number:	CM15-0190881		
Date Assigned:	10/05/2015	Date of Injury:	09/12/2005
Decision Date:	11/10/2015	UR Denial Date:	09/14/2015
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: North Carolina
 Certification(s)/Specialty: Family Practice

CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

This then said 59 year old female sustained an industrial injury on 09-12-2005. Records show that the injured worker was being treated for right shoulder rotator cuff pain, right trapezius pain probable brachial plexopathy, status post right shoulder Mumford resection in 2006, status post right shoulder rotator cuff repair in 2008 and status post right shoulder anterior capsulorrhaphy and mini open biceps tenodesis in 2009. Treatment to date has included physical therapy, surgeries and medications. According to a progress report dated 08-18-2015, the injured worker reported chronic shoulder soreness and chronic neck fatigue and soreness. She reported that physical therapy was helpful while there, but symptoms seemed to recur the following day. Physical examination demonstrated the presence of tenderness over the rotator interval and the subscapularis tendon and mild tenderness over the anterior supraspinatus. There was no tenderness over the mid and posterior supraspinatus, infraspinatus or teres minor. There was no AC joint tenderness. There was no tenderness in the muscle belly of the supraspinatus or infraspinatus. There was no tenderness in the thoracic inlet or outlet. Load and shift testing revealed no grinding or catching and no gross instability anteriorly, inferiorly or posteriorly. Apprehension testing was negative. Resistive testing of rotator cuff strength revealed physiologic strength. Mild pain with Whipple testing was noted. Cervical examination revealed no midline tenderness. There was tenderness in the trapezius and scalenes. Range of motion was physiologic. Spurling maneuver and axial compression test were negative. The provider noted that MRI arthrogram confirmed the absence of any new rotator cuff tearing. The radiologist indicated that there may be anterior labral tearing, but the provider suggested that this was

simply scar tissue formation from her prior surgical procedure several years ago which was an anterior capsulorrhaphy. She was status post biceps tenodesis with absence of the intra-articular portion of the long head of the biceps. On one coronal series, it appeared that there may be a fluid signal in the muscle belly of the supraspinatus. This could not be seen on the other coronal series or on any of the sagittal series. Impression included persistent shoulder and neck discomfort. The treatment plan included evaluation by a cervical specialist. Documentation submitted for review shows that the injured worker had been trying to take Ibuprofen but it caused "severe tinnitus". She had "little improvement" with physical therapy. Physical therapy progress reports were not submitted for review. On 09-14-2015, Utilization Review non-certified the request for physical therapy 2 x weekly for 4 weeks for the right shoulder and neck quantity 8 and modified the request for consultation and treatment with an orthopedic spine specialist for the cervical spine.

IMR ISSUES, DECISIONS AND RATIONALES

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

Physical therapy, 2x weekly for 4 weeks, right shoulder and neck, QTY: 8: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009. Decision based on Non-MTUS Citation Rotator cuff syndrome, pages 26-27.

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

Decision rationale: The California chronic pain medical treatment guidelines section on physical medicine states: Recommended as indicated below. Passive therapy (those treatment modalities that do not require energy expenditure on the part of the patient) can provide short term relief during the early phases of pain treatment and are directed at controlling symptoms such as pain, inflammation and swelling and to improve the rate of healing soft tissue injuries. They can be used sparingly with active therapies to help control swelling, pain and inflammation during the rehabilitation process. Active therapy is based on the philosophy that therapeutic exercise and/or activity are beneficial for restoring flexibility, strength, endurance, function, range of motion, and can alleviate discomfort. Active therapy requires an internal effort by the individual to complete a specific exercise or task. This form of therapy may require supervision from a therapist or medical provider such as verbal, visual and/or tactile instruction(s). Patients are instructed and expected to continue active therapies at home as an extension of the treatment process in order to maintain improvement levels. Home exercise can include exercise with or without mechanical assistance or resistance and functional activities with assistive devices. (Colorado, 2002) (Airaksinen, 2006) Patient-specific hand therapy is very important in reducing swelling, decreasing pain, and improving range of motion in CRPS. (Li, 2005) The use of active treatment modalities (e.g., exercise, education, activity modification) instead of passive treatments is associated with substantially better clinical outcomes. In a large case series of patients with low back pain treated by physical therapists, those adhering to guidelines for active rather than passive treatments incurred fewer treatment visits, cost less, and had less pain and less disability. The overall success rates were 64.7% among those adhering to the active treatment recommendations versus 36.5% for passive

treatment. (Fritz, 2007) Physical Medicine Guidelines: Allow for fading of treatment frequency (from up to 3 visits per week to 1 or less), plus active self-directed home Physical Medicine. Myalgia and myositis, unspecified (ICD9 729.1): 9-10 visits over 8 weeks; Neuralgia, neuritis, and radiculitis, unspecified (ICD9 729.2) 8-10 visits over 4 weeks; Reflex sympathetic dystrophy (CRPS) (ICD9 337.2): 24 visits over 16 weeks. The requested amount of physical therapy is in excess of California chronic pain medical treatment guidelines. The patient has already completed a course of physical therapy. There is no objective explanation why the patient would need excess physical therapy and not be transitioned to active self-directed physical medicine. The request is not medically necessary.

Consultation and treatment with an orthopedic spine specialist, cervical spine: Overturned

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ACOEM Practice Guidelines, Chapter 7: Independent Medical Examinations and Consultations, page 127.

MAXIMUS guideline: Decision based on MTUS General Approaches 2004, Section(s): General Approach to Initial Assessment and Documentation, Initial Approaches to Treatment.

Decision rationale: Per the ACOEM: The health practitioner may refer to other specialist if a diagnosis is uncertain or extremely complex, when psychosocial factors are present, or when the plan or course of care may benefit from additional expertise. A referral may be for: 1. Consultation to aid in the diagnosis, prognosis, therapeutic management, determination of medical stability. The patient has ongoing complaints of significant neck pain that have failed treatment by the primary treating physician. Therefore criteria for a spinal specialist consult have been met and the request is medically necessary.