

Case Number:	CM15-0201915		
Date Assigned:	10/16/2015	Date of Injury:	07/21/2007
Decision Date:	11/30/2015	UR Denial Date:	09/30/2015
Priority:	Standard	Application Received:	10/14/2015

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 62 year old male, who sustained an industrial injury on 7-21-07. Medical records indicate that the injured worker is undergoing treatment for disorders of the bursae and tendons in the shoulder region unspecified, shoulder sprain-strain, partial ankyloses right shoulder and status-post right rotator cuff repair (2009). The injured worker was able to return to work with modified duties. However, the injured workers current work status was not identified. On (8-21-15) the injured worker complained of right shoulder pain with abduction range of motion. Examination of the right shoulder revealed 180 degree forward flexion and 170 degrees abduction. The injured worker underwent a cortisone injection during the visit. The treating physician recommended physical therapy to the right shoulder. Treatment and evaluation to date has included medications, x-rays, cortisone injection, prior physical therapy (2009) and a physical therapy evaluation (9-14-15). A current medication list was not provided in the medical records. The request for authorization dated 8-21-15 was for physical therapy 2-3 times a week for 4 weeks to the right shoulder. The Utilization Review documentation dated 9-30-15 non- certified the request for physical therapy 2-3 times a week for 4 weeks to the right shoulder.

IMR ISSUES, DECISIONS AND RATIONALES

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

Physical therapy 2-3 times a week for 4 weeks right shoulder: Upheld

Claims Administrator guideline: Decision based on MTUS Shoulder Complaints 2004.
Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Physical Therapy Guidelines; Preface.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS.
Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder (Acute & Chronic), physical therapy.

Decision rationale: The claimant sustained a work injury in July 2007 when he was lowering a transformer platform while working as a maintenance mechanic and felt a popping pain in the biceps and shoulder. He continues to be treated for shoulder pain. When seen, he had pain with abduction. There was full range of motion. A cortisone injection was administered and he was referred for up to 12 physical therapy treatment sessions. After a shoulder injection, guidelines recommend up to 1-2 therapy treatment sessions over one week. In this case, the number of visits requested is in excess of that recommended or what would be expected to be needed to review or reestablish the claimant's home exercise program. The request is not considered medically necessary.