

Case Number:	CM15-0202578		
Date Assigned:	10/19/2015	Date of Injury:	08/11/2014
Decision Date:	12/04/2015	UR Denial Date:	10/02/2015
Priority:	Standard	Application Received:	10/15/2015

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: New York
 Certification(s)/Specialty: Anesthesiology

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 48 year old female, who sustained an industrial injury on 8-11-2014. The injured worker is undergoing treatment for: right shoulder pain. On 8-13-2015, she reported currently undergoing physical therapy for the right shoulder and continued pain with restricted mobility. Physical findings revealed well-healed incision, non-tender, and restricted right shoulder range of motion. On 9-2-15, she reported being released back to her job on 8-10-15, and currently experiencing worsened symptoms. Objective findings revealed decreased range of motion to the right shoulder, tenderness over the right shoulder; deep tendon reflexes are symmetric and brisk bilaterally. The records do not discuss the efficacy of the already completed physical therapy sessions. The treatment and diagnostic testing to date has included: ergonomic evaluation (9-1-15), medications, TENS unit, home exercises, right shoulder arthroscopic rotator cuff repair (05/08/2015), unclear amount of completed physical therapy. Medications have included: Lidoderm patches, Voltaren gel, Tylenol PM, Ambien. Current work status: full duty. The request for authorization is for: physical therapy re-evaluation and treatment, 6 sessions for the right shoulder; physical therapy for the right shoulder quantity 6; yoga ball; foam roller; and S3 brace. The UR dated 10-2-2015: non-certified the requests for physical therapy re-evaluation and treatment, 6 sessions for the right shoulder; physical therapy for the right shoulder quantity 6; yoga ball; foam roller; and S3 brace.

IMR ISSUES, DECISIONS AND RATIONALES

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

Physical therapy re-evaluation, right shoulder, Qty 1: Upheld

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

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

Decision rationale: According to the California MTUS Treatment guidelines, physical therapy (PT) is indicated for the treatment of musculoskeletal pain. 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. Patients are instructed and expected to continue active therapies at home as an extension of the treatment process in order to maintain improvement levels. The physical therapy prescription should include diagnosis; type, frequency, and duration of the prescribed therapy; preferred protocols or treatments; therapeutic goals; and safety precautions. According to the ODG, physical therapy for post-surgical treatment of rotator cuff syndrome/impingement syndrome, arthroscopic is 24 visits over 14 weeks. In this case, since there is no documentation of the number of post-operative PT sessions completed, a PT re-evaluation and the request for additional PT sessions are not supported. Medical necessity for the requested service has not been established. The requested service is not medically necessary.

Physical therapy, right shoulder, Qty 6: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Physical Medicine. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Physical Therapy.

Decision rationale: According to the California MTUS Treatment guidelines, physical therapy (PT) is indicated for the treatment of musculoskeletal pain. 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. Patients are instructed and expected to continue active therapies at home as an extension of the treatment process in order to maintain improvement levels. The physical therapy prescription should include diagnosis; type, frequency, and duration of the prescribed therapy; preferred protocols or treatments; therapeutic goals; and safety precautions. According to the ODG, physical therapy for post-surgical treatment of rotator cuff syndrome/impingement syndrome, arthroscopic is 24 visits over 14 weeks. In this case, since there is no documentation of the number of post-operative PT sessions completed, a PT re-evaluation and the request for additional PT sessions

are not supported. Medical necessity for the requested services has not been established. The requested services are not medically necessary.

Yoga ball, Qty 1: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Physical Medicine. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Physical Therapy.

Decision rationale: According to the California MTUS Treatment guidelines, physical therapy (PT) is indicated for the treatment of musculoskeletal pain. 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. Patients are instructed and expected to continue active therapies at home as an extension of the treatment process in order to maintain improvement levels. The physical therapy prescription should include diagnosis; type, frequency, and duration of the prescribed therapy; preferred protocols or treatments; therapeutic goals; and safety precautions. According to the ODG, physical therapy for post-surgical treatment of rotator cuff syndrome/impingement syndrome, arthroscopic is 24 visits over 14 weeks. In this case, since there is no documentation of the number of post-operative PT sessions completed, a PT re-evaluation and the request for additional PT sessions are not supported. In addition, while exercise is recommended, the use of a yoga ball is not supported at this time. Medical necessity for the requested item has not been established. The requested item is not medically necessary.

Foam roller, Qty 1: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Physical Medicine. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Physical Therapy.

Decision rationale: According to the California MTUS Treatment guidelines, physical therapy (PT) is indicated for the treatment of musculoskeletal pain. 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. Patients are instructed and expected to continue active therapies at home as an extension of the treatment process in order to maintain improvement levels. The physical therapy prescription should include diagnosis; type, frequency, and duration of the prescribed therapy; preferred protocols or treatments; therapeutic goals; and safety precautions. According to the ODG, physical therapy for post-surgical treatment of rotator cuff syndrome/impingement syndrome, arthroscopic is 24 visits over 14 weeks. In this case, since there is no documentation of the number of post-

operative PT sessions completed, a PT re-evaluation and the request for additional PT sessions are not supported. In addition, while exercise is recommended, the use of a foam roller is not supported at this time. Medical necessity for the requested item has not been established. The requested item is not medically necessary.

S3 brace, Qty 1: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines: Low Back - Posture garments.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Physical Medicine. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Physical Therapy.

Decision rationale: According to the California MTUS Treatment guidelines, physical therapy (PT) is indicated for the treatment of musculoskeletal pain. 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. Patients are instructed and expected to continue active therapies at home as an extension of the treatment process in order to maintain improvement levels. The physical therapy prescription should include diagnosis; type, frequency, and duration of the prescribed therapy; preferred protocols or treatments; therapeutic goals; and safety precautions. According to the ODG, physical therapy for post-surgical treatment of rotator cuff syndrome/impingement syndrome, arthroscopic is 24 visits over 14 weeks. In this case, since there is no documentation of the number of post-operative PT sessions completed, a PT re-evaluation and the request for additional PT sessions are not supported. In addition, while exercise is recommended, the use of an S3 brace is not supported at this time. Medical necessity for the requested item has not been established. The requested item is not medically necessary.