

<b>Case Number:</b>	CM15-0028550		
<b>Date Assigned:</b>	02/23/2015	<b>Date of Injury:</b>	09/14/2009
<b>Decision Date:</b>	04/20/2015	<b>UR Denial Date:</b>	01/26/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	02/16/2015

### 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 51 year old male, who sustained an industrial injury on September 14, 2009. The diagnoses have included bilateral shoulder impingement syndrome, right shoulder acromioclavicular joint osteoarthritis, right shoulder partial rotator cuff tear and fie and a half month status post right shoulder arthroscopy. Treatment to date has included right shoulder arthroscopy, Magnetic resonance imaging of right shoulder on February 11, 2013 and cortisone injections. Currently, the injured worker complains of right shoulder pain, neck and upper back pain, mid back and low back pain, left shoulder pain, the pain is associated with weakness in hands, numbness in fingers, left foot, toe upper and low back and popping in the right elbow. In a progress note dated August 5, 2014, the treating provider reports examination of the right shoulder was all within normal range, left shoulder positive signs for impingement and restricted range of motion due to pain.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Dynasplint for right shoulder:** Upheld

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

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official disability guidelines shoulder chapter on Dynasplint system.

**Decision rationale:** This patient presents with neck, back, mid back, low back, and left shoulder pain. The patient is status post right shoulder surgery from 02/20/2014. The physician is requesting a DYNASPLINT FOR RIGHT SHOULDER. The RFA was not made available. The patient's date of injury is from 09/14/2009 and he is currently on modified duty. The MTUS and ACOEM guidelines do not address this request. However, the ODG guidelines under the shoulder chapter on Dynasplint system states, "Recommend home use as an option for adhesive capsulitis, in combination with physical therapy instruction. This trial concluded that use of the shoulder Dynasplint system maybe effective adjunct "home therapy" for adhesive capsulitis, combined with PT." The 08/05/2014 progress report show 5/5 strength with flexion, extension, abduction, adduction, internal rotation, and external rotation of the right shoulder, Range of motion was normal. The patient does not have a diagnosis of adhesive capsulitis to the right shoulder. In this case, the patient does not meet the ODG guidelines for Dynasplint system. The request IS NOT medically necessary.

**Physical Therapy for right shoulder twice weekly for 4 weeks: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Postsurgical Treatment Guidelines.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Physical medicine Page(s): 98-99.

**Decision rationale:** This patient presents with neck, back, mid back, low back, and left shoulder pain. The patient is status post right shoulder surgery from 02/20/2014. The physician is requesting a PHYSICAL THERAPY FOR RIGHT SHOULDER TWICE WEEKLY FOR FOUR WEEKS. The RFA was not made available. The patient's date of injury is from 09/14/2009 and he is currently on modified duty. The MTUS Guidelines page 98 and 99 on physical medicine recommends 8 to 10 visits for myalgia, myositis, and neuralgia type symptoms. The patient is past post-operative physical therapy guidelines. The report making the request was not made available. The records do not show any physical therapy reports. The AME report dated 09/22/2014 references a physical therapy note from 04/08/2014 that showed post-operative pain, weakness, and stiffness of the right shoulder. He is gradually progressing per shoulder protocol. In the same report, it shows that the patient has received a total of 16 physical therapy as of 07/15/2014. The patient reports benefit including improve strength and range of motion. In this case, the patient has received 16 physical therapy visits and the requested eight additional would exceed guidelines. The patient should now be able to start a home exercise program to improve strength, flexibility and range of motion. The request IS NOT medically necessary.