

<b>Case Number:</b>	CM15-0213667		
<b>Date Assigned:</b>	11/03/2015	<b>Date of Injury:</b>	06/25/2012
<b>Decision Date:</b>	12/15/2015	<b>UR Denial Date:</b>	10/19/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/30/2015

### 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: Montana, Oregon, Idaho  
 Certification(s)/Specialty: Orthopedic Surgery

### 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 54 year old female, who sustained an industrial-work injury on 6-25-12. She reported initial complaints of right shoulder pain. The injured worker was diagnosed as having chronic right shoulder pain, status post cervical spine injury, surgery and possible residual weakness and right shoulder impingement. Treatment to date has included medication, physical therapy (2012), and surgery (cervical spine in 2014). MRI results were reported lateral outlet stenosis impingement related tendinosis and peritendonitis of both the supraspinatus and infraspinatus tendons distally about the footplate, non-communicating 7 mm interstitial tear of the infraspinatus tendon antero-distally, hypertrophic acromioclavicular joint arthrosis with subacromial-subdeltoid bursitis, and mild to moderate sprain-strain of the coracoclavicular ligament without evidence for acromioclavicular joint separation. X-rays were reported to have normal findings. Currently, the injured worker complains of right shoulder pain rated 6 out of 10. Medication included Norco 5-325 mg. Per the orthopedic consultation report on 9-29-15, exam noted weakness in the right shoulder, positive impingement test, positive Neer's, Hawkin's, and cross body adduction test. An injection was given. Current plan of care includes further evaluation of shoulder. The Request for Authorization requested service to include consult and treatment for the right shoulder and physical therapy evaluation and treatment; 2 to 3 times a week for 4 weeks. The Utilization Review on 10-19-15 denied the request for consult and treatment for the right shoulder and modified physical therapy evaluation and treatment; six visits (3x2).

## IMR ISSUES, DECISIONS AND RATIONALES

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

**Consult and treatment for the right shoulder:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Shoulder Complaints 2004.

**MAXIMUS guideline:** Decision based on MTUS Shoulder Complaints 2004, Section(s): Diagnostic Criteria, Initial Care, Surgical Considerations.

**Decision rationale:** Based upon the CA MTUS Shoulder Chapter. Pages 209-210 recommendations are made for surgical consultation when there is red flag conditions, activity limitations for more than 4 months and existence of a surgical lesion. In this case the submitted documentation indicates that the injured worker has already been evaluated by an Orthopedic Surgeon for right shoulder complaints on 9.29.15. The note from that date indicates that the worker is has been treated with an injection and referral to physical therapy. It is unclear to this reviewer, based on the submitted documentation, why an additional Orthopaedic consultation would be required. Therefore the request is not medically necessary.

**Physical therapy evaluation and treatment; 2 to 3 times a week for 4 weeks:** Upheld

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

**Decision rationale:** ODG Physical Therapy Guidelines "Allow for fading of treatment frequency (from up to 3 visits per week to 1 or less), plus active self-directed home PT. Rotator cuff syndrome/Impingement syndrome: Medical treatment: 10 visits over 8 weeks. Post-injection treatment: 1-2 visits over 1 week. In this case, the injured worker is a 54 year old female who was injured in 2012. She is currently being treated for symptoms of right shoulder impingement. The submitted documentation indicates that she has been treated with an unspecified number of physical therapy visits in 2012. It is unclear to this reviewer whether these visits were directed towards her cervical symptoms, right shoulder symptoms or both. There is no indication from the submitted documentation whether she had functional improvement from prior visits. Therefore, the request for further physical therapy is not supported by the submitted documentation and the request is not medically necessary.