

Case Number:	CM15-0032050		
Date Assigned:	02/25/2015	Date of Injury:	04/20/2009
Decision Date:	04/13/2015	UR Denial Date:	01/27/2015
Priority:	Standard	Application Received:	02/20/2015

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 64-year-old female who reported an injury on 04/20/2009. The mechanism of injury involved a fall. The current diagnoses include cervical intervertebral disc disorder with myelopathy, status post arthroscopic surgery of the shoulder, carpal tunnel syndrome, lumbar intervertebral disc disorder with myelopathy, shoulder periarthritis, and lumbar disc disorder. The injured worker presented on 01/19/2015 with complaints of persistent shoulder pain rated 7/10. The injured worker also reported numbness and tingling in the right posterior wrist and hand. Upon examination of the right shoulder, there were 99 degrees of flexion, 32 degrees of extension, 65 degrees abduction, 16 degrees adduction, 32 degrees internal rotation, and 59 degrees of external rotation. Recommendations included physical therapy for the right shoulder 3 times per week for 8 weeks. There was no Request for Authorization submitted for this review.

IMR ISSUES, DECISIONS AND RATIONALES

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

Physical Therapy to the Right Shoulder, 3 times a week for 8 weeks: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 98 and 99.

Decision rationale: The California MTUS Guidelines state 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. According to the documentation provided, the injured worker has previously participated in a course of physical therapy for the right shoulder. However, there was no documentation of significant functional improvement. Additional treatment would not be supported. Given the above, the request is not medically appropriate.