

Case Number:	CM15-0060402		
Date Assigned:	04/06/2015	Date of Injury:	01/21/2014
Decision Date:	05/05/2015	UR Denial Date:	02/25/2015
Priority:	Standard	Application Received:	03/30/2015

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: California, Indiana, New York
Certification(s)/Specialty: Internal Medicine

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 59-year-old female, who sustained an industrial injury on 1/21/2014. She reported she sustained an injury to the right shoulder and lower back as a caregiver assisting a client to transfer. She was diagnosed with a rotator cuff tear and underwent surgery 5/14/14. She re-injured the rotator cuff ten days post operatively and underwent a second surgery 11/5/14. Diagnoses include right rotator cuff tear, lumbar spondylosis and foraminal narrowing and severe stenosis at L5-S1. Treatments to date include medication therapy, physical therapy, epidural injection, and chiropractic treatments. Currently, she complained pain continuing in the right deltoid area associated with radiation to the right elbow with popping in the elbow. On 2/2/15, the physical examination documented subluxation in the ulnar nerve and medial triceps at the right elbow. The plan of care included physical therapy and continuation of medication therapy.

IMR ISSUES, DECISIONS AND RATIONALES

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

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

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Guidelines, Postsurgical Treatment Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Shoulder chapter.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Page(s): 98-99. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder Section, Physical Therapy.

Decision rationale: Pursuant to the Chronic Pain Medical Treatment Guidelines and the Official Disability Guidelines, physical therapy three times per week for four weeks to the right shoulder is not medically necessary. Patients should be formally assessed after a six visit clinical trial to see if the patient is moving in a positive direction, no direction or negative direction (prior to continuing with physical therapy). When treatment duration and/or number of visits exceeds the guideline, exceptional factors should be noted. In this case, the injured worker's working diagnoses are status post right shoulder rotator cuff repair May 14, 2014; lumbar spondylosis; and foraminal narrowing L4 - L5 and severe L5 - S1. The documentation shows the injured worker had a right rotator cuff repair on May 14, 2014. The injured worker reinjured the shoulder and underwent repeat surgery on November 5, 2014. Physical therapy to the right shoulder and lower back are intermingled throughout the medical record. Utilization review indicates the injured worker receives 24 postoperative physical therapy sessions. When treatment duration and/or number of visits exceeds the guideline, exceptional factors should be noted. There are no compelling clinical facts to warrant additional physical therapy. Subjectively, according to a January 22, 2015 progress note, the injured worker complains of 6/10 right shoulder pain. Objectively, there were no objective findings documented. The documentation does not contain evidence of objective functional improvement with ongoing physical therapy. The injured worker should be well versed in the exercises performed the physical therapy to engage in a home exercise program. Consequently, absent compelling clinical documentation with objective functional improvement having received 24 postoperative physical therapy sessions to the affected shoulder, physical therapy three times per week for four weeks to the right shoulder is not medically necessary.

Physical therapy 2 times a week for 4 weeks for the lumbar spine: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Chronic Pain, Physical Medicine Page(s): 98-99.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Page(s): 98-99. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back Section, Physical Therapy.

Decision rationale: Pursuant to the Chronic Pain Medical Treatment Guidelines and the Official Disability Guidelines, physical therapy two times per week for four weeks to the lumbosacral spine is not medically necessary. Patients should be formally assessed after a six visit clinical trial to see if the patient is moving in a positive direction, no direction or negative direction (prior to continuing with physical therapy). When treatment duration and/or number of visits exceeds the guideline, exceptional factors should be noted. In this case, the injured worker's working

diagnoses are status post right shoulder rotator cuff repair May 14, 2014; lumbar spondylosis; and foraminal narrowing L4 - L5 and severe L5 - S1. The documentation in the record indicates the injured worker received, at a minimum, eight sessions of physical therapy to the lumbar spine. The total number of physical therapy sessions is unclear based on the documentation. Subjectively, a progress note dated January 22, 2015, states the injured worker complains of low back pain with the VAS scale of 6/10 left greater than right lower extremity symptoms. Objectively, there is tenderness of the lumbar spine. Lumbar range of motion is 60% of normal deflection, extension 50% left and right lateral tilt 50%, left rotation 40%. With respect to the lumbar spine, the amount of treatment rendered prior to the request was not available. The ACOEM guidelines in chapter 2 state a complete review of the past history is essential prior to certify any additional treatment or diagnostic testing. The complete documentation of prior physical therapy was not available in the medical record. Consequently, absent clinical documentation with an entire medical record review including all physical therapy to the lumbosacral spine, physical therapy two times per week for four weeks to the lumbosacral spine is not medically necessary.