

Case Number:	CM14-0143181		
Date Assigned:	09/12/2014	Date of Injury:	07/03/2014
Decision Date:	10/29/2014	UR Denial Date:	08/29/2014
Priority:	Standard	Application Received:	09/03/2014

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. The expert reviewer is Board Certified in Anesthesiology, has a subspecialty in Pain Management and is licensed to practice in Florida. 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

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 60-year-old who reported an injury on 07/03/2014. The mechanism of injury was not provided. Her diagnoses included tendinitis of the right shoulder and calcific tendinitis of the right shoulder. The injured worker's past treatments included 10 visits completed of physical therapy, home exercise program, and medication. The injured worker's diagnostic testing included a right shoulder MRI done on 08/20/2014; it was noted to reveal calcific tendinosis at the distal infraspinatus. Small subcortical cyst at the anterior humerus, which is consistent with degenerative change, was also noted. There were no relevant surgeries included. On 08/26/2014, the injured worker was noted to complain of right shoulder pain. She reported that her pain was better than before, and was doing light duty. She reported that her range of motion had improved since she got a cortisone injection on 07/18/2014. Upon physical examination, the injured worker was noted with slight tenderness over the right shoulder and positive impingement sign. The right shoulder range of motion was full with slight pain on end range flexion and abduction. The injured worker's medications included over the counter Advil. The request was for orthopedic consult and physical therapy for the right shoulder. The rationales for the requests were not included. The Request for Authorization form was signed and submitted on 08/26/2014.

IMR ISSUES, DECISIONS AND RATIONALES

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

Orthopedic consult.: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 549-550.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Shoulder, Office Visits

Decision rationale: The Official Disability Guidelines may recommend office visits as determined to be medically necessary. The need for a clinical office visit with a healthcare provider is individualized based upon a review of the patient's concerns, signs and symptoms, clinical stability, and reasonable physician judgment. The determination is also based on what medications the patient is taking, since some medications, such as opiates, require close monitoring. The injured worker was noted to have completed 10 visits of physical therapy, and reported that pain was better than before. The documentation did not provide sufficient evidence of objective functional improvements. She was noted to be using over the counter Advil occasionally for pain. In the absence of documentation of sufficient evidence of significant objective functional deficits, documented evidence of patient concerns, signs, and symptoms that warrant an orthopedic consult, the request is not supported. Therefore, the request is not medically necessary.

Physical therapy for right shoulder Qty 6: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Treatment for Workers Compensation, Chapter Shoulder, (Acute & Chronic) updated 08/27/2014

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

Decision rationale: The California MTUS Guidelines may recommend physical therapy 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. Active therapy requires an internal effort by the individual to complete a specific exercise or task. Patients are instructed and expected to continue active therapies at home as an extension of the treatment process in order to maintain improvement levels. Home exercise can include exercise with or without mechanical assistance or resistance and functional activities with assistive devices. Treatment recommended is up to 10 visits over 8 weeks. The injured worker was noted to have completed 10 visits of physical therapy, and reported that pain was better than before. The documentation did not provide sufficient evidence of objective functional improvements. In the absence of documentation of sufficient evidence with significant objective functional improvements and documented objective decrease in pain, the request is not supported. Additionally, since the patient has completed 10 visits, an additional 6 visits would be excessive. Therefore, the request is not medically necessary.