

Case Number:	CM14-0145726		
Date Assigned:	09/12/2014	Date of Injury:	11/18/2012
Decision Date:	10/14/2014	UR Denial Date:	08/04/2014
Priority:	Standard	Application Received:	09/08/2014

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 Physical Medicine and Rehabilitation and is licensed to practice in California. 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 patient is a 38-year-old male who has submitted a claim for partial superior labrum/biceps tear, right shoulder and acromioclavicular joint damage, right shoulder associated with an industrial injury date of 11/18/2012. Medical records from 04/17/2014 to 08/26/2014 were reviewed and showed that patient complained of constant pain (pain scale grade not specified) in the right shoulder. Physical examination revealed tenderness over AC joint, decreased shoulder ROM, intact strength and sensation of right shoulder, and positive O'Brien's and supraspinatus resistance tests. MR arthrogram of the right shoulder dated 04/28/2014 revealed AC joint contusion/strain and distal supraspinatus and infraspinatus tendon strain. Treatment to date has included unspecified visits of physical therapy, Ultram, and home exercise program. Of note, there was no documentation of functional outcome from previous physical therapy visits. Utilization review dated 08/04/2014 denied the request for S3 posture shirt because posture shirt is not recommended in the absence of a long thoracic nerve injury. Utilization review dated 08/04/2014 denied the request for physical therapy (right shoulder) because there was limited evidence of specific and sustained functional benefit from the treatment period.

IMR ISSUES, DECISIONS AND RATIONALES

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

S3 posture shirt (rental or purchase): Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation www.alignmed.com

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Knee, Durable Medical Equipment

Decision rationale: The CA MTUS does not address this topic. Per the Strength of Evidence hierarchy established by the California Department of Industrial Relations, Division of Workers' Compensation, the Official Disability Guidelines, (ODG), Knee Chapter was used instead. A Durable Medical Equipment (DME) is recommended generally if there is a medical need and if the device meets the Medicare's definition of DME as: can withstand repeated use, is primarily and customarily used to serve a medical purpose, generally is not useful to a person in the absence of illness or injury, and is appropriate for use in a patient's home. In this case, there was no discussion to support the medical need for a posture shirt. The specific material of the posture shirt was not discussed. The medical necessity cannot be established due to insufficient information. Therefore, the request for S3 posture shirt (rental or purchase) is not medically necessary.

Physical therapy (right shoulder): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine. Decision based on Non-MTUS Citation ODG-TWC Shoulder Procedure Summary

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

Decision rationale: According to pages 98-99 of the CA MTUS Chronic Pain Medical Treatment Guidelines, active therapy is recommended for restoring flexibility, strength, endurance, function, range of motion, and can alleviate discomfort. Patients are instructed and expected to continue active therapies at home as an extension of the treatment process in order to maintain improvement levels. Physical medicine guidelines allow for fading of treatment frequency from up to 3 visits per week to 1 or less plus active self-directed home physical medicine. In this case, the patient has already completed unspecified visits of physical therapy. There was no documentation of functional outcome from previous therapy visits. It is unclear as to why the patient cannot transition into HEP. The request likewise failed to indicate the number of physical therapy visits. Therefore, the request for Physical therapy (right shoulder) is not medically necessary.