

Case Number:	CM14-0211665		
Date Assigned:	12/24/2014	Date of Injury:	12/22/2009
Decision Date:	03/10/2015	UR Denial Date:	12/08/2014
Priority:	Standard	Application Received:	12/17/2014

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. 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: Texas, Florida
 Certification(s)/Specialty: Anesthesiology, Pain Management

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 60 year old female who was injured on 12/22/2009. The diagnoses are carpal tunnel syndrome, cervical disc disease, lumbar disc disease, right shoulder and low back pain. There were co-existing diagnoses of anxiety and depression. The past surgery history is significant for right shoulder arthroscopic rotator cuff repair in 2014. The patient completed 8 post operative PT treatments, and progressed to a home exercise program in July 2014. On 11/14/2014, there was subjective complaint of pain in the right shoulder, neck, hands and low back. There were objective findings of positive Tinel and Phalen's tests. There was decreased range of motion and tenderness of painful parts. The patient reported that the PT was helpful. The medications listed are Hydrocodone, Prilosec, Ambien, Colace, Norco, Naprosyn, Lorazepam and Prozac. A Utilization Review determination was rendered on 12/8/2014 recommending non certification for Right Shoulder PT, 2 per week for 4 weeks.

IMR ISSUES, DECISIONS AND RATIONALES

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

Physical therapy for right shoulder; two times a week for four weeks: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Guidelines.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 561-563, Chronic Pain Treatment Guidelines 9792.24.2 Page(s): 98-99.

Decision rationale: The CA MTUS recommend that PT can be utilized for the treatment of musculoskeletal pain. The records indicate that the patient completed post operative PT following right shoulder arthroscopic surgery in July, 2014. The patient reported significant benefits following progression to home exercise program. The guidelines recommend that patients progress to home exercise program upon completion of supervised PT program. The records did not show reductions in medications utilizations following surgery and PT programs. The indications for additional Right Shoulder PT 2 times per week for 4 weeks was not met.