

Case Number:	CM15-0016776		
Date Assigned:	02/05/2015	Date of Injury:	11/02/2011
Decision Date:	03/30/2015	UR Denial Date:	01/20/2015
Priority:	Standard	Application Received:	01/29/2015

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 44-year-old female who reported an injury on 11/02/2011. The mechanism of injury was not provided. The injured worker underwent an MRI arthrography and fluoroscopic arthrogram of the right shoulder on 08/22/2014. There was a Request for Authorization submitted for review dated 01/07/2015. The diagnoses included adhesive capsulitis of the bilateral shoulders and bursitis and tendinitis of the bilateral shoulders. The documentation of 01/07/2015 revealed the injured worker had complaints of constant moderate to severe pain in the bilateral shoulders. Objective findings revealed the injured worker had +4 spasm and tenderness to the right rotator cuff muscles and right upper shoulder muscles. There was +3 spasm and tenderness to the left upper shoulder muscles. The Codman's test was positive on the left. The Speed's test was positive bilaterally as were the supraspinatus test, Neer's test, and push button test. The request was made for an initial 12 postoperative therapy sessions for the right shoulder. The MRI revealed a full thickness tear of the supraspinatus tendon.

IMR ISSUES, DECISIONS AND RATIONALES

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

Physical therapy three (3) times a week for four (4) weeks for the right shoulder: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints, Postsurgical Treatment Guidelines.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Page(s): 98-99, Postsurgical Treatment Guidelines Page(s): 27, 10.

Decision rationale: The California Medical Treatment Utilization Schedule guidelines recommend 10 sessions of therapy for the treatment of myalgia and myositis. The California Medical Treatment Guidelines, Postsurgical Treatment Guidelines, indicate the postsurgical treatment for rotator cuff syndrome/impingement syndrome is 24 visits with the initial number of visits being half the recommended number of visits. The clinical documentation submitted for review indicated there had been a request for surgical intervention for the shoulder. The injured worker was noted to have a full thickness tear of the rotator cuff, which would support the necessity for 12 sessions of therapy. However, the request as submitted was for therapy, not specifically for post-operative therapy and there was no specific dates of service being requested per the request. Given the above, and the lack of clarification, the request for physical therapy 3 times a week times 4 weeks for the right shoulder is not medically necessary.