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| Case Number: | CM15-0113166 | | |
| Date Assigned: | 06/19/2015 | Date of Injury: | 12/14/2010 |
| Decision Date: | 07/20/2015 | UR Denial Date: | 05/28/2015 |
| Priority: | Standard | Application Received: | 06/11/2015 |

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 42 year old male, who sustained an industrial injury on 12/14/2010. He has reported subsequent neck and bilateral shoulder pain and was diagnosed with cervical spine sprain with radiation of the right upper extremity, rule out discopathy, status post right shoulder rotator cuff repair, rule out recurrent rotator cuff pathology and right cubital tunnel syndrome. Treatment to date has included medication and rest. In a progress note dated 05/11/2015, the injured worker complained of cervical pain and bilateral shoulder pain that was rated as 3/10. Objective findings were notable for tenderness to palpation of the cervical spine, tenderness to palpation of the right shoulder and decreased range of motion of the right shoulder. The physician noted that the injured worker continued to have persistent weakness in range of motion of the right shoulder and that occupational therapy was recommended. A request for authorization of occupational therapy 2 times a week for 6 weeks of the right shoulder was submitted.

IMR ISSUES, DECISIONS AND RATIONALES

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

Occupational therapy 2 times a week for 6 weeks, right shoulder: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines 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) Shoulder section, Physical therapy.

Decision rationale: Pursuant to the Chronic Pain Medical Treatment Guidelines and the Official Disability Guidelines, occupational therapy two times per week for six 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 cervical spine sprain with radiation to the right upper extremity; status post right shoulder rotator cuff repair; and right cubital tunnel syndrome. The medical record contains 28 pages. The most recent progress note dated May 11, 2015 states seem to work or has bilateral shoulder pain 3/10 and neck pain 4/10. Objectively, there is tenderness to palpation over the shoulder capsule with minimal decreases in range of motion. There is no documentation indicating the number of physical therapy sessions authorized and received to date and the outcome of physical therapy. There is no documentation demonstrating objective functional improvement. There is no compelling clinical documentation indicating additional physical therapy is clinically indicated. Consequently, absent clinical documentation with prior physical therapy (total number sessions to date), objective functional improvement and compelling clinical documentation indicating additional physical therapy is warranted, occupational therapy two times per week for six weeks to the right shoulder is not medically necessary.