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| Case Number: | CM15-0123248 | | |
| Date Assigned: | 07/07/2015 | Date of Injury: | 08/28/2014 |
| Decision Date: | 07/31/2015 | UR Denial Date: | 06/03/2015 |
| Priority: | Standard | Application Received: | 06/25/2015 |

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: Iowa, Illinois, Hawaii

Certification(s)/Specialty: Preventive Medicine, Occupational Medicine, Public Health & General Preventive 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 (IW) is a 60-year-old female who sustained an industrial injury on 08/28/2014. Diagnoses include full thickness rotator cuff tear of the right shoulder and cervical spine strain with disc herniation at the C5-6 level. Treatment to date has included medications, shoulder surgery and physical therapy, injections and acupuncture. According to the Initial Orthopedic Evaluation Report dated 12/3/14, the IW reported neck pain with radiation to the shoulder and right shoulder pain with weakness. On examination, cervical range of motion was decreased with neurogenic compression tests positive on the right. The trapezius muscles were tender to palpation with mild spasms noted. The right shoulder was severely tender over the anterior aspect with slightly decreased range of motion. Supraspinatus and biceps motor strength was 4+/5. Sensation was intact. Impingement tests I and II and drop arm test were positive. An MRI of the right shoulder on 11/5/14 showed a full-thickness tear of the supraspinatus tendon. A right shoulder arthroscopy was performed on 1/13/15. Physical therapy notes dated 4/23/15 stated the IW was making progress. Her pain was 0-1/10 at rest and 2-4/10 with activity, which was reduced from 5-6/10. She had reduced her use of Hydrocodone from three to four times per week to once or twice a week. She was able to dress without assistance and slept in her bed. A request was made for physical therapy for the right shoulder three times a week for four weeks.

IMR ISSUES, DECISIONS AND RATIONALES

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

Physical therapy right shoulder 2 times a week for 4 weeks: Upheld

Claims Administrator guideline: Decision based on MTUS Postsurgical Treatment Guidelines.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Therapy, Physical Medicine Page(s): 98-99. Decision based on Non-MTUS Citation Shoulder (Acute & Chronic), Physical Therapy, ODG Preface ½ Physical Therapy.

Decision rationale: California MTUS guidelines refer to physical medicine guidelines for physical therapy. Allow for fading of treatment frequency (from up to 3 visits per week to 1 or less), plus active self-directed home Physical Medicine. Regarding physical therapy, ODG states: 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 a negative direction (prior to continuing with the physical therapy); & (6) When treatment duration and/or number of visits exceeds the guideline, exceptional factors should be noted. At the conclusion of this trial, additional treatment would be assessed based upon documented objective, functional improvement, and appropriate goals for the additional treatment. Additionally, ODG states, "Rotator cuff syndrome/Impingement syndrome (ICD9 726. 1; 726. 12): Medical treatment: 10 visits over 8 weeks. Post-injection treatment: 1-2 visits over 1 week. Post-surgical treatment, arthroscopic: 24 visits over 14 weeks. Post-surgical treatment, open: 30 visits over 18 weeks." The medical documentation provided indicate this patient has attended 24 sessions of physical therapy, which is consistent with MTUS and ODG guidelines. The treating physician has not provided documentation as to why this patient cannot be transitioned to a home exercise program. As such, the request for Physical therapy right shoulder 2 times a week for 4 weeks is not medically necessary.