MAXIMUS Federal Services

Case Number:	CM15-0171549		
Date Assigned:	10/01/2015	Date of Injury:	02/19/2015
Decision Date:	11/20/2015	UR Denial Date:	08/12/2015
Priority:	Standard	Application Received:	08/31/2015

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: Arizona, California
Certification(s)/Specialty: Family Practice

CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

This is a 56 year old male with a date of injury of February 19, 2015. A review of the medical records indicates that the injured worker is undergoing treatment for right shoulder strain, right shoulder impingement, right shoulder bursitis, right shoulder tendinitis, and thoracic and lumbar spine sprain and strain. Handwritten medical records dated May 5, 2015 indicate that the injured worker reported temporary benefit from chiropractic treatments for the right shoulder but continues with pain. A handwritten progress note dated June 26, 2015 documented complaints of right shoulder pain rated at a level of 8 out of 10, and thoracic and lumbar spine pain rated at a level of 8 out of 10. Per the treating physician (June 26, 2016), the employee was to return to modified work duties that included no lifting over five pounds. The physical exam dated May 5, 2015 reveals right shoulder tenderness decreased range of motion of the right shoulder, thoracic spine tenderness, decreased range of motion of the thoracic spine, lumbar spine tenderness, and decreased range of motion of the lumbar spine. The progress note dated June 26, 2015 documented a physical examination that similar findings to those documented on May 5, 2015, along with positive straight leg raise. Portions of the progress notes were difficult to decipher. Treatment has included chiropractic treatments, and at least one session of acupuncture. The original utilization review (August 12, 2015) non-certified a request for a right shoulder subacromial injection under ultrasound guidance, and partially certified a request for ten sessions of physical therapy for the thoracic spine, lumbar spine, and right shoulder (original request for twelve sessions).

IMR ISSUES, DECISIONS AND RATIONALES

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

Physical therapy 2 times per week for 6 weeks (lumbar spine, Thoracic spine and right shoulder): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Shoulder Chapter: Physical therapy guidelines and Lumbar chapter: Physical/Occupational Therapy.

MAXIMUS guideline: Decision based on MTUS Shoulder Complaints 2004, Section(s): Initial Care, Activity Modification, and Low Back Complaints 2004, Section(s): Inital Care, Physical Methods, and Chronic Pain Medical Treatment 2009, Section(s): Physical Medicine.

Decision rationale: According to the guidelines, physical therapy is recommended for 8-10 sessions in a fading frequency. Additional exercises can be completed at home. In this case, there was no indication that therapy cannot be completed at home. The claimant was already prescribed home exercises. The request for 12 physical therapy sessions exceeds the guidelines recommendations and is not medically necessary.

Right shoulder subacromial injection under ultrasound guidance: Upheld

Claims Administrator guideline: Decision based on MTUS Shoulder Complaints 2004. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Shoulder Chapter (online version): Steroid injections.

MAXIMUS guideline: Decision based on MTUS Shoulder Complaints 2004, Section(s): Summary.

Decision rationale: According to the guidelines, injections are recommended for rotator cuff tears, impingement and inflammation. It is not routinely performed under image guidance. In this case, there is a diagnosis of shoulder impingement with painful range of motion; however, the need for ultrasound guidance was not substantiated and is not medically necessary.