MAXIMUS Federal Services

Case Number:	CM15-0174205		
Date Assigned:	09/16/2015	Date of Injury:	12/28/2013
Decision Date:	10/16/2015	UR Denial Date:	08/05/2015
Priority:	Standard	Application Received:	09/03/2015

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: Massachusetts
Certification(s)/Specialty: Physical Medicine & Rehabilitation, 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 57-year-old female injured worker suffered an industrial injury on 12-28-2013. The diagnoses included cervical spine sprain-strain, cervical radiculopathy, left shoulder pain, lumbar spine strain-sprain, and lumbar radiculopathy. On 6-2-2015, the AME noted prior treatments included 5-29-2014 right shoulder arthroscopy with rotator cuff repair followed by unknown number of sessions of post-operative physical therapy and chiropractic therapy 1-2015 with unknown number of sessions. In 3-2015 and 4-2015, acupuncture was added without benefit. On 7-28-2015, the treating provider reported constant pain to both shoulders rated as 6 out of 10. She reported stiffness and constant pain to the cervical spine and that the pain radiated down both arms and hands accompanied with tingling and numbness. She reported her fingers lock up sometimes. On exam, the right shoulder had very limited painful range of motion. The Utilization Review on 8-5-2015 determined non-certification for Physical therapy 3 x 3 for the right shoulder.

IMR ISSUES, DECISIONS AND RATIONALES

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

Physical therapy 3 x 3 for the right shoulder: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) (1) Chronic pain, Physical medicine treatment. (2) Preface, Physical Therapy Guidelines (3) Shoulder (Acute & Chronic) Physical therapy.

Decision rationale: The claimant sustained a work injury in December 2013 and is being treated for right shoulder pain. She underwent right shoulder arthroscopic surgery with a rotator cuff repair in May 2014 with poor recovery with marked stiffness. In April 2015, a continued self- directed home exercise program was being recommended. When seen, she was attending acupuncture. She was having constant bilateral shoulder and cervical pain with radiating upper extremity pain and numbness and tingling. She was having occasional finger locking. There was decreased and painful range of motion with positive impingement testing. The claimant is being treated for chronic shoulder pain. In terms of physical therapy treatment for chronic pain, guidelines recommend a six visit clinical trial with a formal reassessment prior to continuing therapy. In this case, the claimant has already had physical therapy including a home exercise program, which was being performed independently in April 2015. Continued compliance with a home exercise program would be expected and could include use of TheraBands and a home pulley system for strengthening and range of motion. In this case, the number of visits requested is in excess of that recommended or what might be needed to reestablish or revise the claimant's home exercise program. The request is not medically necessary.