

Case Number:	CM15-0072177		
Date Assigned:	05/01/2015	Date of Injury:	11/12/2014
Decision Date:	06/10/2015	UR Denial Date:	03/16/2015
Priority:	Standard	Application Received:	04/15/2015

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: 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:

The injured worker is a 54 year old female, who sustained an industrial injury on 11/12/2014. She has reported injury to the right shoulder. The diagnoses have included acute pain of right shoulder; closed non-displaced fracture of greater tuberosity of right humerus; and frozen shoulder syndrome. Treatment to date has included medications, diagnostics, injection, and physical therapy. Medications have included Tramadol and Celebrex. A progress note from the treating physician, dated 01/30/2015, documented a follow-up visit with the injured worker. Currently, the injured worker complains of right shoulder pain with intermittent radiating pain; pain is rated 6/10 on the visual analog scale, and 8-9/10 at its worst; has completed 6 weeks of physical therapy; and the pain and symptoms have not decreased. Objective findings included tenderness to the right shoulder bursa and bicipital groove; decreased range of motion and strength; and positive Neer's, Jobe's, supraspinatus, and O'Brien's tests. The treatment plan has included the request for physical therapy re-evaluation and treatment, 2-3 times weekly for 4-6 weeks 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 re-evaluation and treatment, 2-3 times weekly for 4-6 weeks for the right shoulder: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Page(s): 99.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines physical medicine Page(s): 98.

Decision rationale: Based on guidelines physical medicine can provide short-term relief during the early phases of pain treatment and are directed at controlling symptoms such as pain, inflammation and swelling and to improve the rate of healing soft tissue injuries. They can be used sparingly with active therapies to help control swelling, pain and inflammation during the rehabilitation process. There should be documented functional improvement. There should be a home exercise program. Based on the medical records there is no documentation that the patient has had improvement with previous physical therapy or if there is a home exercise program and thus not medically necessary.