

Case Number:	CM17-0014320		
Date Assigned:	01/27/2017	Date of Injury:	11/04/2016
Decision Date:	02/22/2017	UR Denial Date:	01/13/2017
Priority:	Standard	Application Received:	01/23/2017

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: 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 44 year old female who sustained an industrial injury on 11-4-16. The injured worker reported discomfort in the right shoulder. A review of the medical records indicates that the injured worker is undergoing treatments for frozen right shoulder, impingement syndrome right shoulder, unspecified sprain of right shoulder joint and sprain of joints and ligaments of other parts of neck. Medical records dated 1-3-17 indicate pain rated at 9 out of 10. Provider documentation dated 1-3-17 noted the work status as modified duties. Treatment has included Celecoxib, Cyclobenzaprine, physical therapy, injection therapy, and acupuncture treatments. Objective findings dated 1-3-17 were notable for restricted cervical range of motion, paracervical muscles tenderness, and right wrist with radial tenderness to palpation. The original utilization review (1-13-17) denied a request for twelve physical therapy visits for the Cervical Spine and partially approved a request for nine physical therapy visits for the right shoulder was authorized by the Claims Administrator. Twelve physical therapy visits for the right shoulder was the original request. The remaining IMR eligible portion of the original request, three physical therapy visits for the right shoulder.

IMR ISSUES, DECISIONS AND RATIONALES

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

Twelve physical therapy visits for the right shoulder was the original request. Nine physical therapy visits for the right shoulder was authorized by the Claims Administrator. The remaining IMR eligible portion of the original request, three physical therapy visits for the right shoulder is: Upheld

Claims Administrator guideline: Decision based on MTUS Neck and Upper Back Complaints 2004, Section(s): Initial Care, and Shoulder Complaints 2004. Decision based on Non-MTUS Citation Official Disability Guidelines, Neck and Upper Back Chapter, Shoulder Chapter, Physical therapy.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2016, Section(s): Physical medicine treatment. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder section, Physical therapy.

Decision rationale: Requested Treatment: Twelve physical therapy visits for the right shoulder was the original request. Nine physical therapy visits for the right shoulder was authorized by the Claims Administrator. The remaining IMR eligible portion of the original request, three physical therapy visits for the right shoulder, is not medically necessary. Pursuant to the Chronic Pain Medical Treatment Guidelines 2016 and the Official Disability Guidelines, the remaining IMR eligible portion of the original request 3 physical therapy visits to the right shoulder is not medically necessary. Physical medicine encompasses interventions that are within the scope of various practitioners (including Physical Therapy, Occupational Therapy, Chiropractic, and MD/DO). Passive therapy (those treatment modalities that do not require energy expenditure on the part of the patient) is not indicated for addressing chronic pain in most instances; refer to the specific modality within these guidelines (e.g., massage, ultrasound). Active therapy is based on the philosophy that therapeutic exercise and/or activity are beneficial for restoring flexibility, strength, endurance, function, range of motion, and can alleviate discomfort. Active therapy requires an internal effort by the individual to complete a specific exercise or task. Refer to the specific intervention within these guidelines (e.g., exercise.) This form of therapy may require supervision from a therapist or medical provider such as verbal, visual and/or tactile instruction(s). 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 frozen right shoulder, impingement syndrome right shoulder, unspecified sprain of right shoulder joint and sprain of joints and ligaments of other parts of neck. Date of injury is November 4, 2016. Request for authorization is January 9, 2017. According to a January 3, 2017 new patient consultation, subjective complaints include right shoulder pain, 9/10. This injured worker received three physical therapy visits. The injured worker also complains of left shoulder pain and burning that radiates to the elbow. Medication includes Celecoxib 200 mg and cyclobenzaprine 10 mg (prescribed by the other physician). Objectively, the cervical spine is mildly stiff with restricted range of motion. There is tenderness in the paracervical muscles and trapezius. Left shoulder movements are restricted. Hawkin's and Neer's are positive; there is tenderness at the biceps groove and subdeltoid bursa. Flexion is 100, abduction 80, internal rotation 30, and external rotation 60. The treatment plan contains a request for physical therapy 23 (six visits) and Norco 5/325 mg. The injured worker is working modified duty. The

documentation indicates the injured worker received three sessions of physical therapy with improvement. The guidelines recommend 10 physical therapy visits over eight weeks for a sprain strain shoulder. There was a peer-to-peer conference (undated) between the utilization reviewer and treating provider. The treating provider agreed to a modification from 12 sessions of physical therapy to 9 physical therapy sessions for the shoulder only. There are no compelling clinical facts to support the full complement of 12 physical therapy visits to the right shoulder. Based on clinical information in the medical record and the peer-reviewed evidence-based guidelines, the remaining IMR eligible portion of the original request 3 physical therapy visits to the right shoulder is not medically necessary.

Twelve physical therapy visits for the Cervical Spine: Upheld

Claims Administrator guideline: Decision based on MTUS Neck and Upper Back Complaints 2004, Section(s): Initial Care. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Neck and Upper Back Chapter, Physical Therapy (PT), subheading.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2016, Section(s): Physical medicine treatment. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Neck section, Physical therapy.

Decision rationale: Pursuant to the Chronic Pain Medical Treatment Guidelines 2016 and the Official Disability Guidelines, twelve physical therapy visits for the cervical spine are not medically necessary. Physical medicine encompasses interventions that are within the scope of various practitioners (including Physical Therapy, Occupational Therapy, Chiropractic, and MD/DO). Passive therapy (those treatment modalities that do not require energy expenditure on the part of the patient) is not indicated for addressing chronic pain in most instances; refer to the specific modality within these guidelines (e.g., massage, ultrasound). Active therapy is based on the philosophy that therapeutic exercise and/or activity are beneficial for restoring flexibility, strength, endurance, function, range of motion, and can alleviate discomfort. Active therapy requires an internal effort by the individual to complete a specific exercise or task. Refer to the specific intervention within these guidelines (e.g., exercise.) This form of therapy may require supervision from a therapist or medical provider such as verbal, visual and/or tactile instruction(s). 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 frozen right shoulder, impingement syndrome right shoulder, unspecified sprain of right shoulder joint and sprain of joints and ligaments of other parts of neck. Date of injury is November 4, 2016. Request for authorization is January 9, 2017. According to a January 3, 2017 new patient consultation, subjective complaints include right shoulder pain, 9/10. This injured worker received three physical therapy visits. The injured worker also complains of left shoulder pain and burning that radiates to the elbow. Medication includes Celecoxib 200 mg and cyclobenzaprine 10 mg (prescribed by the other physician). Objectively, the cervical spine is mildly stiff with restricted range of motion. There is tenderness in the paracervical muscles and trapezius. Left shoulder movements are restricted. Hawkin's and Neer's are positive; there is tenderness at the biceps groove and subdeltoid bursa. Flexion is 100, abduction 80, internal

rotation 30, and external rotation 60. The treatment plan contains a request for physical therapy 23 (six visits) and Norco 5/325 mg. The injured worker is working modified duty. There was a peer-to-peer conference (undated) between the utilization reviewer and treating provider. The treating provider agreed to a modification from 12 sessions of physical therapy to 9 physical therapy sessions for the shoulder only. The treating provider agreed physical therapy to the neck is not necessary. Additionally, there were no cervical spine/neck complaints. Consequently, physical therapy to the cervical spine 12 sessions is not clinically indicated. Based on the clinical information in the medical record and the peer-reviewed evidence-based guidelines, twelve physical therapy visits for the cervical spine are not medically necessary.