

Case Number:	CM13-0021430		
Date Assigned:	12/11/2013	Date of Injury:	07/03/2012
Decision Date:	06/12/2014	UR Denial Date:	08/23/2013
Priority:	Standard	Application Received:	09/09/2013

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. The expert reviewer is Board Certified in Physical Medicine and Rehabilitation, and is licensed to practice in California. 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

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 43-year-old sustained an injury on July 3, 2012 while employed by [REDACTED]. Request under consideration include physical therapy two (2) times a week for six (6) weeks to the right shoulder. report of July 10, 2013 from the provider noted the patient with continuous complaints of shoulder weakness. Exam showed range of motion improved since March; range in abduction at 80-95 degrees; flexion 90-145 degrees; internal rotation of 30/30 degrees. Diagnosis was post-operative biceps tenodesis with decrease range of motion. Per Physical Therapy report of July 25, 2013, the patient reported 25% better overall with PT to right shoulder; still with limited biceps strength and difficulty with range of motion in lifting. Exam showed 5/5 motor strength throughout except for 4/5 at deltoid; range of motion dated 4/30/13 showed flexion at 115 degrees, abd at 115 degrees and rotation at 50 degrees. Range on July 25, 2013 showed flex/abd of 135/125 degrees. Diagnoses was unspecified sprain/strain. The patient had minimal progress with range of motion since last re-evaluation. Request for PT to the right shoulder was non-certified on August 23, 2013 citing guidelines criteria and lack of medical necessity.

IMR ISSUES, DECISIONS AND RATIONALES

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

PHYSICAL THERAPY TWO (2) TIMES A WEEK FOR SIX (6) WEEKS TO THE RIGHT SHOULDER: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines
PHYSICAL THERAPY Page(s): 98-99.

Decision rationale: This 43 year-old male sustained an injury on July 3, 2012 while employed by [REDACTED]. Request under consideration include physical therapy (PT) two times weekly for six weeks to the right shoulder. Report of July 10, 2013 from the provider noted the patient with continuous complaints of shoulder weakness. Exam showed range of motion improved since March; range in abduction at 80-95 degrees; flexion 90-145 degrees; internal rotation of 30/30 degrees. Diagnosis was post-operative biceps tenodesis with decrease range of motion. Per Physical Therapy report of July 25, 2013, the patient reported 25% better overall with PT to right shoulder; still with limited biceps strength and difficulty with range of motion in lifting. Exam showed 5/5 motor strength throughout except for 4/5 at deltoid; range of motion dated April 30, 2013 showed flexion at 115 degrees, abd at 115 degrees and rotation at 50 degrees. Range on July 25, 2013 showed flex/abd of 135/125 degrees. Diagnoses was unspecified sprain/strain. The patient had minimal progress with range of motion since last re-evaluation. The patient has completed formal sessions of PT and there is nothing submitted to indicate functional improvement from treatment already rendered. There is no report of new acute injuries that would require a change in the functional restoration program. There is no report of acute flare-up and the patient has been instructed on a home exercise program for this injury. Per Guidelines, physical therapy is considered medically necessary when the services require the judgment, knowledge, and skills of a qualified physical therapist due to the complexity and sophistication of the therapy and the physical condition of the patient. However, there is no significant functional change with measurable evidence of progress with the PT treatment already rendered including milestones of increased ROM, strength, and functional capacity. Review of submitted physician reports showed plateau in clinical findings and function with unchanged chronic symptom complaints and work status. There is no evidence documenting functional baseline with clear goals to be reached and the patient striving to reach those goals. The Chronic Pain Guidelines allow for 9-10 visits of physical therapy with fading of treatment to an independent self-directed home program. The request for physical therapy to the right shoulder, twice weekly for six weeks, is not medically necessary of appropriate.