

Case Number:	CM13-0034281		
Date Assigned:	12/06/2013	Date of Injury:	11/18/2012
Decision Date:	02/20/2014	UR Denial Date:	09/27/2013
Priority:	Standard	Application Received:	10/15/2013

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Physical Medicine and Rehabilitation and is licensed to practice in Oklahoma and Texas. 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 physician 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:

The patient is a 46-year-old female who reported an injury on 11/18/2012. The patient is currently diagnosed with myofascial sprain and strain of the cervical spine with left upper extremity radiculopathy, myofascial sprain and strain of the thoracic spine, left shoulder sprain and strain, left rib costochondritis, rule out left cubital tunnel syndrome versus radiculopathy, cervical disc bulge, left rotator cuff tendinosis, SLAP lesion of the left shoulder, and left shoulder early adhesive capsulitis. The patient was seen by [REDACTED] on 09/23/2013. Physical examination of the left shoulder revealed tenderness over the rotator cuff muscle and trapezius muscle, decreased range of motion, positive apprehension test and impingement sign, and diminished grip strength on the left. Treatment recommendations included continuation of physical therapy to the left shoulder at a frequency of 2 times per week for 4 weeks.

IMR ISSUES, DECISIONS AND RATIONALES

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

Physical therapy (2) times a week for (4) weeks for the left shoulder: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Page(s): 98-99.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 98-99. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG); Shoulder Chapter, Physical Therapy.

Decision rationale: The California MTUS Guidelines state that active therapy is based on the philosophy that therapeutic exercise and/or activity both are beneficial for restoring flexibility, strength, endurance, function, range of motion, and can alleviate discomfort. The guidelines allow for a fading of treatment frequency plus active self-directed home physical medicine. As per the clinical documentation submitted, the patient has previously undergone physical therapy for the left shoulder. Documentation of the previous course of treatment with total duration and efficacy was not provided for review. Therefore, ongoing treatment cannot be determined as medically appropriate. Based on the clinical information received, the request for Physical Therapy (2) times a week for (4) weeks for left shoulder is non-certified.