

Case Number:	CM13-0041511		
Date Assigned:	12/20/2013	Date of Injury:	09/16/2011
Decision Date:	04/18/2014	UR Denial Date:	10/07/2013
Priority:	Standard	Application Received:	10/15/2013

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 & 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 45 year-old male sustained an injury on 9/16/11 while employed by [REDACTED]. Request under consideration include PHYSICAL THERAPY 2X/WK X 4WKS LEFT SHOULDER. Per report of 5/20/13, the patient is s/p left shoulder arthroscopy with acromioplasty, excision of inferior lateral clavicle. Physical therapy report of 9/10/13 noted patient continued with mild to moderate left shoulder pain with stiffness in upper extremity elevation motion of daily activities. Pain described at 7/10 at worst and 1/10 at best. Initial evaluation of 7/23/13 noted muscle strength of 4/5 in shoulder abduction and 4-/5 in flexion and ER; active range in flex/abd/ER were 115/140/30 degrees. Reevaluation of 9/10/13 noted muscle strength at 4/5 in all planes with range of flex/abd/ER at 130/130/30 degrees with noted stiffness in left shoulder girdle musculature. Diagnoses was shoulder joint pain. Current medications list Norco. EMG of 10/10/12 noted C5-6 radiculopathy. Request for above physical therapy was non-certified on 10/7/13 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 2XWK X 4WKS LEFT SHOULDER: Upheld

Claims Administrator guideline: Decision based on MTUS Postsurgical Treatment Guidelines Page(s): 27.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines, Postsurgical Treatment Guidelines Page(s): 27.

Decision rationale: This 45 year-old male sustained an injury on 9/16/11 while employed by [REDACTED]. Request under consideration include PHYSICAL THERAPY 2X/WK X 4WKS LEFT SHOULDER. Per report of 5/20/13, the patient is s/p left shoulder arthroscopy with acromioplasty, excision of inferior lateral clavicle. Physical therapy report of 9/10/13 noted patient continued with mild to moderate left shoulder pain with stiffness in upper extremity elevation motion of daily activities. Pain described at 7/10 at worst and 1/10 at best. Initial evaluation of 7/23/13 noted muscle strength of 4/5 in shoulder abduction and 4-/5 in flexion and ER; active range in flex/abd/ER were 115/140/30 degrees. Reevaluation of 9/10/13 noted muscle strength at 4/5 in all planes with range of flex/abd/ER at 130/130/30 degrees with noted stiffness in left shoulder girdle musculature. Diagnoses was shoulder joint pain. Current medications list Norco. EMG of 10/10/12 noted C5-6 radiculopathy. 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 clear measurable evidence of progress with the PT treatment already rendered including milestones of increased ROM, strength, and functional capacity. It appears from the PT progress reports the patient has plateaued in both strength and range. Review of submitted physician reports show no evidence of functional benefit, unchanged chronic symptom complaints, nonspecific clinical findings, 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 physical therapy with fading of treatment to an independent self-directed home program. The employee has received PT visits for the arthroscopic repair 10 months ago; however without identified number of visits or demonstrated evidence of functional improvement to allow for additional therapy treatments. Post-surgical guidelines allow for up to 24 visits post arthroscopic shoulder repair over a rehab period of 6 months. The PHYSICAL THERAPY 2X/WK X 4WKS LEFT SHOULDER is not medically necessary and appropriate.