

Case Number:	CM13-0042137		
Date Assigned:	12/27/2013	Date of Injury:	10/15/2012
Decision Date:	02/12/2014	UR Denial Date:	10/02/2013
Priority:	Standard	Application Received:	10/16/2013

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 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 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:

This 42 year-old male sustained an injury on 10/15/12 while at his place of employment. Request under consideration include physical therapy 2 times a week times 3 weeks to the left shoulder. Report dated 9/18/13 from [REDACTED] noted patient complained of bilateral shoulder pain and is 4.5 months s/p subacromial decompression and bursocopy (5/2/13). He is attending physical therapy and performing home exercises with slow progress. He complained of pain at lateral aspect, numbness, tingling to middle, ring and small fingers; popping and weakness. Exam of left shoulder revealed tenderness to lateral bursa; normal range of motion (ER 90, IR 50, flex 160 degrees); medications include Voltaren, Vicodin, Wellbutrin, Lamictal, Norco. Treatment plan included continuing PT 2x3 to left shoulder which was non-certified on 10/2/13 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 2 times a week times 3 weeks to the left shoulder: Upheld

Claims Administrator guideline: Decision based on MTUS Postsurgical Treatment Guidelines.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines, Postsurgical Treatment Guidelines.

Decision rationale: This 42 year-old male sustained an injury on 10/15/12 while at his place of employment. Request under consideration include physical therapy 2 times a week times 3 weeks to the left shoulder. Report dated 9/18/13 from [REDACTED] noted patient complained of bilateral shoulder pain and is 4.5 months s/p subacromial decompression and bursocopy (5/2/13). He is attending physical therapy and performing home exercises with slow progress. He complained of pain at lateral aspect, numbness, tingling to middle, ring and small fingers; popping and weakness. Exam of left shoulder revealed tenderness to lateral bursa; normal range of motion (ER 90, IR 50, flex 160 degrees); medications include Voltaren, Vicodin, Wellbutrin, Lamictal, Norco. 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 physical therapy (PT) treatment already rendered including milestones of increased range of motion (ROM), strength, and functional capacity. Review of submitted physician reports show no evidence of functional benefit, unchanged chronic symptom complaints, 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 at least 36 formal PT visits for the arthroscopic repair 9 months ago without demonstrated evidence of functional improvement to allow for additional therapy treatments. Submitted reports have not demonstrated the medical necessity for additional PT outside the recommended quantity of post-operative therapy sessions already exceeded. The physical therapy 2 times a week times 3 weeks to the left shoulder is not medically necessary and appropriate.