

Case Number:	CM13-0067827		
Date Assigned:	05/07/2014	Date of Injury:	06/11/2001
Decision Date:	08/22/2014	UR Denial Date:	12/05/2013
Priority:	Standard	Application Received:	12/18/2013

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 Occupational Medicine 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:

The patient is a 43-year-old female who has submitted a claim for left shoulder pain, associated with an industrial injury date of June 11, 2001. Medical records from 2013 through 2014 were reviewed. The latest progress report, dated 01/17/2014, showed constant neck pain and frequent pain in the left shoulder, which radiated to the left side of the neck. The patient experienced popping sensation in the left shoulder but denied any dislocation. There was difficulty in performance of daily activities. Physical examination of the left shoulder revealed an exaggerated reaction. There was full range of motion but stiffened with elevation. The effort was questionable. Motor function of the upper extremities was met with cogwheel breakaway weakness. No objective weakness was identified. Treatment to date has included left shoulder posterior labral repair 03/28/2013, post-op physical therapy on left shoulder (04/08/2013 to 06/28/2013), and medications. Utilization review from 12/05/2013 modified the request for physical therapy/occupational therapy from 2 times per week for 6 to 8 weeks into 2x/week for 5 weeks. Reasons for modification were not made available.

IMR ISSUES, DECISIONS AND RATIONALES

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

PHYSICAL THERAPY 2 TIMES PER WEEK FOR 6-8 WEEKS: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines PHYSICAL MEDICINE GUIDELINES Page(s): 99.

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

Decision rationale: According to pages 98-99 of the CA MTUS Chronic Pain Medical Treatment Guidelines, active therapy is recommended for restoring flexibility, strength, endurance, function, range of motion, and can alleviate discomfort. Patients are instructed and expected to continue active therapies at home as an extension of the treatment process in order to maintain improvement levels. In addition, guidelines allow for fading of treatment frequency from up to 3 visits per week to 1 or less plus active self-directed home physical medicine. In this case, the patient had post-op physical therapy of the left shoulder from 04/08/2013 to 06/28/2013. The patient opted for discharge and was hesitant with compliance in the physical therapy sessions. There was still persistence of pain on the left shoulder associated with limitation of functional activities. The rationale of requesting physical therapy was to strengthen and stabilize the left shoulder. The current progress notes did not document functional gains with previous PT and with the addition of previous non-compliance from lack of self-motivation, the medical necessity was not established. Moreover, the request failed to specify body part to be treated. Therefore, the request for physical therapy 2x/week for 6-8 weeks is not medically necessary.

OCCUPATIONAL THERAPY 2 TIMES PER WEEK FOR 6-8 WEEKS: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Guidelines Page(s): 99. Decision based on Non-MTUS Citation ODG Shoulder, Physical Therapy and ODG Neck and Upper Back, Physical Therapy.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines 9792.24.2, PHYSICAL MEDICINE Page(s): 98-99.

Decision rationale: According to pages 98-99 of the CA MTUS Chronic Pain Medical Treatment Guidelines, active therapy is recommended for restoring flexibility, strength, endurance, function, range of motion, and can alleviate discomfort. Patients are instructed and expected to continue active therapies at home as an extension of the treatment process in order to maintain improvement levels. In addition, guidelines allow for fading of treatment frequency from up to 3 visits per week to 1 or less plus active self-directed home physical medicine. In this case, the patient had post-op physical therapy of the left shoulder from 04/08/2013 to 06/28/2013. The patient opted for discharge and was hesitant with compliance in the physical therapy sessions. There was still persistence of pain on the left shoulder associated with limitation of functional activities. The rationale of requesting physical therapy was to strengthen and stabilize the left shoulder. The current progress notes did not document functional gains with previous PT and with the addition of previous non-compliance from lack of self-motivation, the medical necessity was not established. Moreover, the request failed to specify body part to be treated. Therefore, the request for occupational therapy 2x/week for 6-8 weeks is not medically necessary.

