

Case Number:	CM14-0004683		
Date Assigned:	02/05/2014	Date of Injury:	02/24/2012
Decision Date:	06/20/2014	UR Denial Date:	12/17/2013
Priority:	Standard	Application Received:	01/10/2014

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:

According to the records made available for review, this is a 68-year-old female with a February 24, 2012 date of injury, and right shoulder arthroscopic decompression with partial distal clavicle resection and partial rotator cuff tear with debridement on November 30, 2012. At the time of request for authorization for physical therapy once per week for eight weeks to the right shoulder and referral to pain management specialist for possible cervical spine epidural injection (December 13, 2013), there is documentation of subjective (right shoulder pain with difficulty with overhead activities, and cervical and lumbar spine pain) and objective (right shoulder range of motion with flexion at 110 degrees and abduction at 110 degrees, cervical and lumbar spine paraspinal muscle tenderness, and painful range of motion) findings, current diagnoses (internal injury to shoulders and lumbar spine, status post right shoulder surgery), and treatment to date (medications and physical therapy). Medical report identifies a request for patient to continue physical therapy 1x8 as patient continues to have pain, weakness, loss of motion and functional deficits of the right shoulder, cervical spine, and lumbar spine. Regarding physical therapy once per week for eight weeks to the right shoulder, there is no documentation of functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications or medical services as a result of physical therapy provided to date. Regarding referral to pain management specialist for possible cervical spine epidural injection, there is no documentation of subjective and objective radicular findings in each of the requested nerve root distributions, and an imaging report at each of the requested levels.

IMR ISSUES, DECISIONS AND RATIONALES

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

PHYSICAL THERAPY ONCE PER WEEK FOR EIGHT WEEKS TO THE RIGHT SHOULDER: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation MTUS: ACOEM, ,

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation MTUS: CHRONIC PAIN MEDICAL TREATMENT, PHYSICAL MEDICINE, 98

Decision rationale: The Chronic Pain Medical Treatment Guidelines support a brief course of physical medicine for patients with chronic pain not to exceed ten visits over four to eight weeks with allowance for fading of treatment frequency, with transition to an active self-directed program of independent home physical medicine/therapeutic exercise. MTUS-Definitions identifies that any treatment intervention should not be continued in the absence of functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications or medical services. ODG recommends a limited course of physical therapy for patients with a diagnosis of adhesive capsulitis not to exceed 16 visits over 8 weeks. ODG also notes patients should be formally assessed after a "six-visit clinical trial" to see if the patient is moving in a positive direction, no direction, or a negative direction (prior to continuing with the physical therapy) and when treatment requests exceeds guideline recommendations, the physician must provide a statement of exceptional factors to justify going outside of guideline parameters. Within the medical information available for review, there is documentation of diagnoses of internal injury to shoulders and lumbar spine, status post right shoulder surgery. In addition, given documentation of a request for patient to continue physical therapy, once weekly for eight weeks, as patient continues to have pain, weakness, loss of motion and functional deficits of the right shoulder, cervical spine, and lumbar spine, there is documentation of previous physical therapy treatments. However, there is no documentation of the number of previous physical therapy sessions and, if the number of treatments have exceeded guidelines, remaining functional deficits that would be considered exceptional factors to justify exceeding guidelines. In addition, there is no documentation of functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications or medical services as a result of physical therapy provided to date. The request for physical therapy to the right shoulder, once per week for eight weeks, is not medically necessary or appropriate.