

Case Number:	CM14-0116619		
Date Assigned:	08/04/2014	Date of Injury:	08/26/2010
Decision Date:	09/10/2014	UR Denial Date:	07/17/2014
Priority:	Standard	Application Received:	07/25/2014

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 & 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:

The injured worker is a 46-year-old female who reported an injury on 08/26/2010. The mechanism of injury was not provided for clinical review. The diagnoses included left shoulder symptomatic biceps tendon tear, AC arthritis and impingement. Previous treatments included 24 sessions of physical therapy, medication, and surgery. Within the clinical note dated 01/23/2014, it was reported the injured worker complained of left shoulder pain. She rated her pain at a 10/10 in severity. Per the physical examination, the provider noted increased pain in the left shoulder and left wrist. The provider noted clicking and popping in the left shoulder. The injured worker was unable to adduct her arm past 60 degrees. The injured worker was able to abduct her arm 80 and flexion at 70 degrees. The provider noted the injured worker had a positive Hawkin's and apprehension tests. The request submitted is for physical therapy 2 times a week for 6 weeks. However, a rationale is not provided for clinical review. The request for authorization was not submitted for clinical review.

IMR ISSUES, DECISIONS AND RATIONALES

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

Physical therapy: two (2) times a week for six (6) weeks.: Upheld

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

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

Decision rationale: The request for Physical Therapy 2 times a week for 6 weeks is not medically necessary. The injured worker complained of left shoulder pain. She rated her pain 5/10 in severity. The California MTUS Guidelines state that state active therapy is based on the philosophy that therapeutic exercise and/or activity are beneficial for restoring flexibility, strength, endurance, function, and range of motion. The guidelines allow for a fading of treatment frequency plus active self-directed home physical medicine. The guidelines note for neuralgia and myalgia 8 to 10 visits of physical therapy are recommended. The request was submitted for 12 sessions of physical therapy exceeds the guidelines' recommendation of 8 to 10 visits. There is a lack of documentation indicating the efficacy of the injured worker's previous 24 sessions of physical therapy. There is a lack of documentation including an adequate and complete physical examination demonstrating the injured worker had decreased functional ability and decreased strength and flexibility. Therefore, the request is not medically necessary.