

Case Number:	CM14-0135118		
Date Assigned:	08/27/2014	Date of Injury:	02/22/2011
Decision Date:	10/02/2014	UR Denial Date:	07/30/2014
Priority:	Standard	Application Received:	08/14/2014

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 Texas. 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:

Medical Records reflect the claimant is a 57 year old female who was injured on 02/22/2011. The mechanism of injury is unknown. Prior treatment history has included home exercise program, injection to the left shoulder, TENS, Celebrex and 11 documented sessions of physical therapy. On physical therapy note dated 05/13/2014, the patient noted her pain to be a 5/10 with improvement. On 06/02/2014, her pain was noted as 3/10. Progress report dated 07/14/2014 states the patient presented with known rotator cuff proximal biceps tendinosis. She reported left shoulder pain with activities but denies catching and locking. Objective findings on exam revealed full range of motion of the left shoulder. There is tenderness to palpation along the acromioclavicular joint. She has a positive Hawkins as well as Neers test. She has mild reproduction of pain with cross reduction. Impression is subacromial subdeltoid bursitis and acromioclavicular joint synovitis. The patient was recommended for additional physical therapy, 8 sessions. Prior utilization review dated 07/30/2014 states the request for Physical therapy left shoulder 1-2x12 is denied as there is no indication for additional therapy.

IMR ISSUES, DECISIONS AND RATIONALES

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

Physical therapy left shoulder 1-2x12: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Page(s): 98-99. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder Chapter - physical therapy

Decision rationale: The Chronic Pain Medical Treatment Guidelines as well as ODG notes that physical therapy is recommended, but one should allow for fading of treatment frequency (from up to 3 visits per week to 1 or less), plus active self-directed home physical medicine. Medical Records reflect the injured worker has had 11 physical therapy sessions. It is felt that this patient should already be exceeding well-versed in an exercise program. It is not established that a return to supervised physical therapy is medically necessary and likely to significantly improve or impact the patient's overall pain level and functional status beyond that of her actively utilizing an independent home exercise program. Based on the Chronic Pain Medical Treatment Guidelines, ODG guidelines, as well as the clinical documentation stated above, the request is not medically necessary.