

Case Number:	CM14-0167673		
Date Assigned:	10/15/2014	Date of Injury:	10/01/2008
Decision Date:	11/18/2014	UR Denial Date:	09/10/2014
Priority:	Standard	Application Received:	10/10/2014

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 50-year-old female with a 10/1/08 date of injury, and right shoulder arthroscopy on 8/5/11. At the time (9/5/14) of request for authorization for Physical therapy right shoulder, right upper extremity, there is documentation of subjective (constant right shoulder pain) and objective (moderate tenderness to palpitation over the acromioclavicular joint, subacromial space, and bicipital groove; diminished range of motion of the right shoulder; and positive Apley's test, Drop test, Empty Cane test, and cross arm test) findings, current diagnoses (right shoulder tendinitis, right frozen shoulder, bilateral carpal tunnel syndrome, and right shoulder subacromial decompression), and treatment to date (6 sessions of physical therapy and medications). Medical report identifies a request for 2 sessions X4 weeks of physical therapy.

IMR ISSUES, DECISIONS AND RATIONALES

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

Physical therapy right shoulder, right upper extremity: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints, Chapter 11 Forearm, Wrist, and Hand Complaints.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines physical medicine Page(s): 98. Decision based on Non-MTUS Citation Official Disability Guidelines

(ODG: Shoulder, Physical Therapy (PT). Other Medical Treatment Guideline or Medical Evidence: Title 8, California Code of Regulations, section 9792.20

Decision rationale: MTUS Chronic Pain Medical Treatment Guidelines support a brief course of physical medicine for patients with chronic pain not to exceed 10 visits over 4-8 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 Rotator cuff syndrome/Impingement syndrome not to exceed 10 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 right shoulder tendinitis, right frozen shoulder, bilateral carpal tunnel syndrome, and right shoulder subacromial decompression. In addition, there is documentation of a request for an 8 sessions of physical therapy treatment. However, given documentation of 6 previous physical therapy treatments, 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 as a result of previous physical therapy treatments. In addition, given the requested 8 additional physical therapy treatments, in addition to the treatments already completed, which would exceed guidelines, there is no documentation of a statement of exceptional factors to justify going outside of guideline parameters. Therefore, based on guidelines and a review of the evidence, the request for Physical therapy right shoulder, right upper extremity is not medically necessary.