

Case Number:	CM14-0173359		
Date Assigned:	10/24/2014	Date of Injury:	09/11/2008
Decision Date:	12/03/2014	UR Denial Date:	10/07/2014
Priority:	Standard	Application Received:	10/20/2014

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 Illinois. 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 59-year-old female who reported an injury on 09/11/2008. The mechanism of injury was not provided. On 05/08/2014, the injured worker presented with low back pain. The diagnoses were left greater than right shoulder pain and low back pain. Upon examination, the deep tendon reflexes were equal and symmetrical in the bilateral lower extremities. There were no upper trap findings. The injured worker had a lumbosacral orthotic in place and the lumbar range of motion was limited in both flexion and extension. The included medications and topical analgesics. The provider recommended physical therapy for the left shoulder. The provider's rationale was not provided. The Request for Authorization form was not included in the medical documents for review.

IMR ISSUES, DECISIONS AND RATIONALES

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

Physical Therapy 2 times a week for 6 weeks Left Shoulder: 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.

Decision rationale: The request for physical therapy to the left shoulder is not medically necessary. The California MTUS states that active therapy is based on the philosophy that therapeutic exercise and/or activity are beneficial for restoring flexibility, strength, endurance, function, range of motion, and can alleviate discomfort. Active therapy requires an internal effort by the individual to complete a specific exercise or task. The injured worker is instructed and expected to continue active therapies at home as an extension of the treatment process in order to maintain improvement levels. There was a lack of documentation indicating the injured worker's prior course of physical therapy as well as the efficacy of the prior therapy. The guidelines recommend up to 10 visits of physical therapy for over 4 weeks. The amount of physical therapy visits that were already completed was not provided. Additionally, there was a lack of functional deficits upon physical examination. There are no significant barriers to transitioning the injured worker to an independent home exercise program. As such, medical necessity has not been established.