

Case Number:	CM14-0176479		
Date Assigned:	10/29/2014	Date of Injury:	10/15/1990
Decision Date:	12/05/2014	UR Denial Date:	10/16/2014
Priority:	Standard	Application Received:	10/24/2014

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 Emergency Medicine 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:

Patient with reported date of injury on 10/15/1990. No mechanism of injury was provided for review. Patient has a diagnosis of bilateral shoulder impingement syndrome, subacromial bursitis and osteoarthritis of lumbar spine with sciatica. There is no provided documentation of any prior surgeries. Medical reports reviewed. Last report available until 9/24/14. All the notes provided are hand written progress notes with variable legibility. Last note documents complains of L leg pain. L shoulder pain radiates to L ahdn. Objective exam only documents tenderness to subacromial bursa and positive impingement. Note does not give reason for PT. Note from 9/1/14 and 9/24/14 notes request for PT with no documentation of rationale. Note from 9/1/14 documents that pt feels the same and both shoulder have pain. Review of 4 prior visits show similar complains of shoulder pains. No imaging or electrodiagnostic reports were provided for review. Only medications documented are Lidocaine patch and Lodine. There is no documentation of prior conservative treatment modalities such as physical therapies, exercise program etc. Independent Medical Review is for physical therapy 3/week for 6weeks (18total) for L shoulder. Prior UR on 10/16/14 recommended non-certification.

IMR ISSUES, DECISIONS AND RATIONALES

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

Physical therapy 3 times weekly times 6 weeks, left shoulder: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical medicine Page(s): 98-99.

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

Decision rationale: As per MTUS Chronic pain guidelines physical therapy is recommended for many situations with evidence showing improvement in function and pain. The provider fails all necessary documentation necessary to recommend physical therapy. There is no documentation of medical justification of PT. There is no documentation of prior physical therapy and improvement or response to therapy. There is no appropriate documentation of pain scale or what the long term plan for therapy is. Guidelines also recommend only up to 10 PT sessions for the diagnosis listed, the number of sessions requested is excessive. Physical therapy of L shoulder is not medically necessary.