

Case Number:	CM14-0036920		
Date Assigned:	06/25/2014	Date of Injury:	08/30/2007
Decision Date:	07/31/2014	UR Denial Date:	02/26/2014
Priority:	Standard	Application Received:	03/26/2014

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 Orthopedic Surgery 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:

The injured worker is a 49-year-old female with a reported injury on 08/30/2007. The mechanism of injury was not provided within the clinical notes. The clinical note dated 05/14/2014 reported that the injured worker complained of left shoulder pain. The physical examination of the injured worker's left shoulder revealed active range of motion demonstrating flexion to 150 degrees, extension to 40 degrees, abduction to 110 degrees, adduction to 25 degrees, internal rotation to 60 degrees, and external rotation to 70 degrees. The injured worker's diagnoses include left shoulder impingement syndrome, left shoulder sprain/strain, superior glenoid labrum. The injured worker's prescribed medication list included naproxen, Tylenol with codeine, and Prilosec. The provider requested physical therapy to the injured worker's left shoulder. The rationale was not provided within the clinical notes. The request for authorization was submitted 03/26/2014. The injured worker's previous treatments were not provided within the clinical note.

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 four (4) weeks, for the left shoulder: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines.

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

Decision rationale: The injured worker complained of left shoulder pain. The treating physician's rationale for physical therapy was not provided within the clinical notes. The Chronic Pain Guidelines indicate that active therapy requires an internal effort by the individual to complete a specific exercise or task. This form of therapy may require supervision from a therapist or medical provider such as verbal, visual and/or tactile instruction(s). Patients are instructed and expected to continue active therapies at home as an extension of the treatment process in order to maintain improvement levels. Home exercise can include exercise with or without mechanical assistance or resistance and functional activities with assistive devices. Within the provided documentation, an adequate and complete assessment of the injured worker's functional condition was not provided; there is a lack of clinical documentation indicating the injured worker has significant functional deficits. Given the information provided, there is insufficient evidence to determine appropriateness of physical therapy to warrant medical necessity; as such, the request is not medically necessary.