

Case Number:	CM14-0055204		
Date Assigned:	07/07/2014	Date of Injury:	04/27/2008
Decision Date:	09/23/2014	UR Denial Date:	04/11/2014
Priority:	Standard	Application Received:	04/24/2014

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 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:

This 43 year-old patient sustained an injury on 4/27/08 while employed by [REDACTED]. Request(s) under consideration include Physical therapy 3x4 for the left shoulder. MRI of left shoulder dated 1/17/12 showed partial-thickness tear of distal infraspinatus tendon with narrowing of coracoacromial arch. Report of 3/27/14 from the provider noted the patient is 4 weeks follow-up for subacromial decompression of left shoulder. The patient has received 24 total physical therapy visits to date. Complaints include pain and weakness with activities of pushing/pulling. Exam showed left shoulder elevation 160 degrees with moderate rotator cuff weakness. Plan included continuing with PT x 12. Request(s) for Physical therapy 3x4 for the left shoulder was non-certified on 4/11/14 citing guidelines criteria and lack of medical necessity.

IMR ISSUES, DECISIONS AND RATIONALES

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

Physical therapy 3x4 for the left shoulder: Upheld

Claims Administrator guideline: Decision based on MTUS Postsurgical Treatment Guidelines.

MAXIMUS guideline: Decision based on MTUS Postsurgical Treatment Guidelines.

Decision rationale: This 43 year-old patient sustained an injury on 4/27/08 while employed by Target Corporation. Request(s) under consideration include Physical therapy 3x4 for the left

shoulder. MRI of left shoulder dated 1/17/12 showed partial-thickness tear of distal infraspinatus tendon with narrowing of coracoacromial arch. Report of 3/27/14 from the provider noted the patient is 4 weeks follow-up for subacromial decompression of left shoulder. The patient has received 24 total physical therapy visits to date. Complaints include pain and weakness with activities of pushing/pulling. Exam showed left shoulder elevation 160 degrees with moderate rotator cuff weakness. Plan included continuing with PT x 12. Request(s) for Physical therapy 3x4 for the left shoulder was non-certified on 4/11/14. Physical therapy is considered medically necessary when the services require the judgment, knowledge, and skills of a qualified physical therapist due to the complexity and sophistication of the therapy and the physical condition of the patient. However, there is no clear measurable evidence of progress with the PT treatment already rendered including milestones of increased ROM, strength, and functional capacity. Review of submitted physician reports show no evidence of functional benefit, unchanged chronic symptom complaints, clinical findings, and work status. There is no evidence documenting functional baseline with clear goals to be reached and the patient striving to reach those goals. The Chronic Pain Guidelines allow for physical therapy with fading of treatment to an independent self-directed home program. The employee has received at least 24 authorized PT visits for the arthroscopic repair without demonstrated evidence of functional improvement to allow for additional therapy treatments. Chronic Pain Guidelines, post-operative therapy allow for 24 visits over 14 weeks for shoulder arthroscopy with postsurgical physical medicine treatment period of 6 months. Submitted reports have not adequately demonstrated the indication to support further physical therapy beyond the guidelines criteria. The Physical Therapy 3x4 for the Left Shoulder is not medically necessary and appropriate.