

Case Number:	CM14-0084575		
Date Assigned:	07/21/2014	Date of Injury:	12/10/2013
Decision Date:	11/26/2014	UR Denial Date:	05/09/2014
Priority:	Standard	Application Received:	06/06/2014

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, has a subspecialty in Pain 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:

This is a patient with a date of injury of December 10, 2013. A utilization review determination dated May 9, 2014 recommends non-certification of additional physical therapy. An evaluation dated February 13, 2014 identifies subjective complaints of left shoulder pain rated at 7/10 which is worse with overhead lifting and activities of daily living. An MRI shows tendinitis. Physical examination findings revealed normal shoulder range of motion, normal sensation, normal strength, no tenderness over the shoulder, and positive New Year's sign and Hawkins sign. The note then goes on to state that her range of motion is restricted. Diagnoses include left shoulder injury with rotator cuff tendinitis. The treatment plan recommends physical therapy twice a week for 6 weeks and continue NSAID medication. A physical therapy evaluation dated February 26, 2014 identifies decreased strength and range of motion in the left shoulder. A progress report dated March 27, 2014 states that the patient has completed 8 sessions of physical therapy with excellent progress to range of motion. The patient's left shoulder forward flexion and abduction are now 145. The treatment plan recommends continued aggressive physical therapy. The diagnosis states that the patient's shoulder was immobilized for more than 2 months in a sling with significant atrophy and decrease in range of motion and degradation of functional use. A steroid injection was provided at that appointment. A progress report dated April 23, 2014 states that the patient had a popping sensation while doing physical therapy with severe pain which has since resolved. The note indicates that the patient's range of motion and strength have continued to improve. Additional physical therapy is recommended working on range of motion and strength.

IMR ISSUES, DECISIONS AND RATIONALES

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

Additional physical therapy for the left shoulder 2x6 weeks: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Page(s): 114. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Physical Therapy Guidelines

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 200. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Shoulder Chapter, Physical Therapy

Decision rationale: Regarding the request for additional physical therapy, Chronic Pain Medical Treatment Guidelines recommend a short course of active therapy with continuation of active therapies at home as an extension of the treatment process in order to maintain improvement levels. ODG has more specific criteria for the ongoing use of physical therapy. ODG recommends a trial of physical therapy. If the trial of physical therapy results in objective functional improvement, as well as ongoing objective treatment goals, then additional therapy may be considered. ODG recommends 10 visits over 8 weeks for the treatment of rotator cuff syndrome/impingement syndrome. Within the documentation available for review, there is documentation of completion of prior PT sessions. But there is no documentation of specific objective functional deficits that cannot be addressed within the context of an independent home exercise program, yet are expected to improve with additional formal supervised therapy. Furthermore, the request exceeds the amount of PT recommended by the CA MTUS and, unfortunately, there is no provision for modification of the current request. In light of the above issues, the currently requested additional physical therapy is not medically necessary.