

Case Number:	CM14-0095622		
Date Assigned:	07/25/2014	Date of Injury:	01/18/2013
Decision Date:	10/03/2014	UR Denial Date:	06/06/2014
Priority:	Standard	Application Received:	06/23/2014

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 Louisiana. 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 patient is a 52 year old female who was injured on 01/18/2013 when he fell injuring his left shoulder. Prior medication history included ibuprofen and Meloxicam. Prior treatment history has included physical therapy with benefit. The patient underwent left shoulder arthroscopy, debridement of degenerative labral tearing and chondroplasty, humeral head on 01/08/2014. Diagnostic studies reviewed include x-rays of left shoulder dated 05/20/2014 revealed status post distal clavicle excision and acromioplasty. Progress report dated 05/20/2014 documented the patient to have complaints of pain present over the anterior aspect of the left shoulder without distal pain radiation or paresthesias. Objective findings on exam revealed left shoulder active and passive range of motion revealed forward elevation at 160 degrees with mild substitution, external rotation to 50 degrees; internal rotation to sacrum; abducted external rotation 70 degrees; abducted internal rotation to 40 degrees. The patient is diagnosed with slow progress post left rotator cuff repair, subacromial decompression distal clavicle excision. The patient is recommended continued physical therapy twice a week for 6 weeks. There are no previous physical therapy notes available for review documented functional improvement. Prior utilization review dated 06/06/2014 states the request for Physical Therapy 2x week x 6 weeks, Left Shoulder is denied as medical necessity has not been established.

IMR ISSUES, DECISIONS AND RATIONALES

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

Physical Therapy 2x week x 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): 98-99. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Shoulder, Physical therapy

Decision rationale: Based on the Chronic Pain Medical Treatment Guidelines, Physical Therapy is recommended for both a passive portion for acute short-term relief and active methods to maintain improvement levels. Guidelines require documentation of objective improvements with previous treatment, functional deficits, functional goals, and a statement identifying why an independent home exercise plan program would be insufficient. In this case, there is a lack of supporting documentation of progression or functional improvement from prior physical therapy provided to indicate the necessity of this request, therefore it is not medically necessary at this time.