

Case Number:	CM14-0186928		
Date Assigned:	11/19/2014	Date of Injury:	03/01/2013
Decision Date:	01/07/2015	UR Denial Date:	10/26/2014
Priority:	Standard	Application Received:	11/10/2014

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 Preventive Medicine, has a subspecialty in Occupational Medicine and is licensed to practice in Iowa. 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 63 year old person with date of injury 3/1/13. Medical records indicate the patient is undergoing treatment for possible Complex Regional Pain Syndrome Type 1, status post left rotator cuff repair 1/6/14. Subjective complaints include constant stabbing and aching pain rated 9/10; reports difficulty sleeping due to the pain; worsening with any movement of left shoulder or arm; worse with grasping objects or reaching out for objects and some alleviation of pain is noted with stretching and light exercises. Objective findings include presence of allodynia upon mild palpation of left shoulder capsule; left shoulder range of motion to approximately 60 degrees; extension to approximately 30 degrees and internal rotation goes to approximately the left sacroiliac joint; manual muscle testing reveals 4/5 diffusely throughout left shoulder joint and is limited by pain and sensation reveals allodynia in left shoulder and proximal left arm. Treatment has included physical therapy, aqua therapy, shoulder sling, and medications including Trazodone, Norco, Lyrica, Neurontin, and Tizanidine. The utilization review determination was rendered on 10/26/14 recommending non-certification of Additional Physical Therapy 2 x week for 3 weeks Left Shoulder.

IMR ISSUES, DECISIONS AND RATIONALES

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

Additional Physical Therapy 2 x week for 3 weeks Left Shoulder: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Therapy, Physical Medicine Page(s): 98-99. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Shoulder (Acute & Chronic), Physical Therapy, ODG Preface - Physical Therapy

Decision rationale: California MTUS guidelines refer to physical medicine guidelines for physical therapy. "Allow for fading of treatment frequency (from up to 3 visits per week to 1 or less), plus active self-directed home Physical Medicine." Regarding physical therapy, ODG states "Patients should be formally assessed after a "six-visit clinical trial" to see if the patient is moving in a positive direction, no direction, or a negative direction (prior to continuing with the physical therapy); & (6) When treatment duration and/or number of visits exceeds the guideline, exceptional factors should be noted." At the conclusion of this trial, additional treatment would be assessed based upon documented objective, functional improvement, and appropriate goals for the additional treatment. The treating physician has not provided documentation of this patient's response to the 32 previous physical therapy sessions or current program goals. The number of sessions attended is already in excess of guideline recommendations. As such, the request for Addition Physical Therapy 2 x week for 3 weeks is not medically necessary.