

Case Number:	CM14-0193119		
Date Assigned:	11/26/2014	Date of Injury:	11/17/2011
Decision Date:	01/13/2015	UR Denial Date:	11/03/2014
Priority:	Standard	Application Received:	11/18/2014

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 patient sustained an injury on 11/17/11 while employed by [REDACTED]. Request(s) under consideration include Physical therapy, 2 times a week for 4 weeks. Diagnoses include quadriplegia with constipation and bladder dysfunction, right shoulder adhesive capsulitis s/p cervical spine fusion C3-4, s/p right shoulder arthroscopy/ SAD, distal clavical resection and labrum debridement on 7/24/14. Report of 10/27/14 noted chronic ongoing bilateral shoulder pain rated at 5/10, right forearm pain at 2/10 and bilateral legs/feet at 4-5/10; patient been undergoing post-op PT. Exam showed unchanged limited shoulder range with flex/abd of 160/180 and 130/170 degrees; diffuse motor 4/5 weakness with abductors and internal rotators. The request(s) for Physical therapy, 2 times a week for 4 weeks was non-certified on 11/3/14 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, 2 times a week for 4 weeks: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Therapy Page(s): 98-99.

Decision rationale: This patient sustained an injury on 11/17/11 while employed by [REDACTED]. Request(s) under consideration include Physical therapy, 2 times a week for 4 weeks. Diagnoses include quadriplegia with constipation and bladder dysfunction, right shoulder adhesive capsulitis s/p cervical spine fusion C3-4, s/p right shoulder arthroscopy/ SAD, distal clavical resection and labrum debridement on 7/24/14. Report of 10/27/14 noted chronic ongoing bilateral shoulder pain rated at 5/10, right forearm pain at 2/10 and bilateral legs/feet at 4-5/10; patient been undergoing post-op PT. Exam showed unchanged limited shoulder range with flex/abd of 160/180 and 130/170 degrees; diffuse motor 4/5 weakness with abductors and internal rotators. The request(s) for Physical therapy, 2 times a week for 4 weeks was non-certified on 11/3/14. Review indicates the patient had completed 157 physical therapy sessions. Submitted reports have no acute flare-up or specific physical limitations to support for physical therapy. 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 9-10 visits of physical therapy with fading of treatment to an independent self-directed home program. It appears the employee has received significant therapy sessions without demonstrated evidence of functional improvement to allow for additional therapy treatments. There is no report of acute flare-up, new injuries, or change in symptom or clinical findings to support for formal PT in a patient that has been instructed on a home exercise program for this chronic injury. Submitted reports have not adequately demonstrated the indication to support further physical therapy when prior treatment rendered has not resulted in any functional benefit. The Physical therapy, 2 times a week for 4 weeks is not medically necessary and appropriate.