

Case Number:	CM15-0002034		
Date Assigned:	01/13/2015	Date of Injury:	05/15/2000
Decision Date:	03/17/2015	UR Denial Date:	12/03/2014
Priority:	Standard	Application Received:	01/05/2015

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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:

State(s) of Licensure: California, New York, Florida

Certification(s)/Specialty: Internal Medicine, Pulmonary Disease, Critical Care Medicine

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 injured worker is a 61-year-old male who reported an injury on 05/15/2000. The mechanism of injury was not provided. On 11/20/2014, the injured worker presented with complaints of pain to the shoulder. Upon examination, there was diffuse tenderness to the shoulder. Provider was unable to test the rotator cuff due to pain/stiffness. An x-ray was unremarkable for arthritis. Diagnoses were reflex sympathetic dystrophy versus frozen shoulder. Provider recommended 18 physical therapy sessions for the left shoulder 3 times a week for 6 weeks. There was no rationale provided. The Request for Authorization form was dated 11/24/2014.

IMR ISSUES, DECISIONS AND RATIONALES

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

18 Physical Therapy for the left shoulder, 3 times a week for 6 weeks, as an out-patient:

Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Page(s): 98,99,of 127.

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

Decision rationale: The request for 18 Physical Therapy for the left shoulder, 3 times a week for 6 weeks, as an out-patient is not medically necessary. The California MTUS Guidelines state active therapy is based on the philosophy that therapeutic exercise and/or activity are beneficial for restoring flexibility, strength, endurance, function, range of motion, and can alleviate discomfort. Active therapy requires an internal effort by the individual to complete a specific exercise or task. Injured workers are instructed and expected to continue active therapies at home as an extension of the treatment process in order to maintain improvement levels. There is lack of documentation indicating if the injured worker had prior therapy sessions and the efficacy of those sessions were not provided for review. Additionally, the guidelines recommend 10 visits over 4 weeks. The provider's request exceeds the guideline recommendations. As such, medical necessity has not been established.