

Case Number:	CM15-0140697		
Date Assigned:	07/30/2015	Date of Injury:	02/15/2013
Decision Date:	08/27/2015	UR Denial Date:	07/13/2015
Priority:	Standard	Application Received:	07/20/2015

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

Certification(s)/Specialty: Physical Medicine & Rehabilitation

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 72 year old female with an industrial injury dated 02/15/2013. The injury is documented as occurring when her chair was moved out from under her and she fell on her left side hitting her knee against a desk. She notes injury to hip, back, neck, left arm and knee along with pain in her left upper back and shoulder. Her diagnosis was left shoulder impingement, rotator cuff tear. Co morbid conditions include hypertension and chronic obstructive pulmonary disease. She has a history of multiple health issues and hospitalization as documented in the 02/25/2015 note. Prior treatment included physical therapy (24 visits), medications and surgery. She presents on 04/01/2015 with complaints of shoulder pain and limitations in strength and motion. She was 8 months from her left shoulder arthroscopy with acromioplasty, distal clavicle excision and large rotator cuff (tear) repair. She continued to have discomfort, limits in motion and weakness. Physical exam noted left shoulder tighter than previously. There was tightness at the end points with testing. Strength was limited with anterior and lateral tenderness. There was also posterior tenderness which is documented as less than anterior and lateral tenderness. The provider notes this is a complex large tear in a complicated patient. The treatment plan recommended physical therapy along with home exercise program. The treatment request is for physical therapy, left shoulder, 2 times weekly for 6 weeks, 12 sessions.

IMR ISSUES, DECISIONS AND RATIONALES

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

Physical Therapy, Left Shoulder, 2 times wkly for 6 wks, 12 sessions: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine, Postsurgical Treatment Guidelines.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Therapy, pages 98-99.

Decision rationale: The patient is s/p shoulder arthroscopy in September 2014, almost 1 year prior and has completed at least 24 PT visits. Chronic Treatment Guidelines are applicable. Although as noted by the provider that this is a complex large tear in a complicated patient, there is no identified post-operative complications from the arthroscopic surgery nor is there demonstrated functional benefit from the therapy already rendered. 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 functional 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 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, Left Shoulder, 2 times wkly for 6 wks, 12 sessions is not medically necessary or appropriate.