

Case Number:	CM15-0149404		
Date Assigned:	08/12/2015	Date of Injury:	04/06/1999
Decision Date:	09/10/2015	UR Denial Date:	07/22/2015
Priority:	Standard	Application Received:	07/31/2015

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, Pain Management

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 62 year old female, who sustained an industrial injury on 4-6-99. Initial complaints were not reviewed. The injured worker was diagnosed as having chronic lumbar pain with radiculopathy; left hip bursitis; bilateral shoulder tendinosis; bilateral carpal tunnel syndrome; breast cancer history; depression; anxiety. Treatment to date has included physical therapy and medications. Currently, the PR-2 notes dated 6-10-15 indicated the injured worker returns for an evaluation after her last visit in this office on 3-14-12. She reports she has received treatment over the past year and has received treatment for left breast cancer and remains on Tamoxifen. She has not been "indicated to have either chemotherapy or radiation therapy". She reports worsening of her several orthopedic complaints with the exception of the low back pain. Her low back pain and lower extremity symptoms continue to respond well to the stimulator, which is functioning well for her. During her treatment process, she has undergone a right hip arthroplasty but reports to have problems with the left hip. Her knee complaints have worsened and she is using a walker for ambulation due to the hip and knee pain bilaterally. In addition, she reports worsening neck pain, shoulder and upper extremity pain. She reports difficulty doing any frequent work with upper extremities especially the left side, which is associated with weakness as well as shoulder and neck pain. Without pain medications, her level of severity is 8 out of 10. She is currently taking Gabapentin, which is beneficial. She is seeing a psychiatrist who is addressing her anxiety and she remains on Xanax. On physical examination, she has mild tenderness over the lumbar spine with decreased range of motion. The site of the stimulator is without any abnormalities. She has limited range of motion of the bilateral shoulders with a healed incision site on the right with positive impingement on the left.

She has a healed incision on the left wrist with positive Tinel's and Phalen's bilaterally with no atrophy but decreased grip is noted. There is tenderness over the medial and lateral joints especially on the left side with decreased flexion and positive McMurray's on both sides. She has no edema in the lower extremities. She has a surgical history of lumbar fusion, spinal cord stimulator implant, right hip arthroplasty; right shoulder arthroscopic surgery; left carpal tunnel release and a history of left breast cancer. The provider is requesting authorization of 12 physical therapy sessions for the right shoulder, 2x/week for 6 weeks as an outpatient.

IMR ISSUES, DECISIONS AND RATIONALES

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

12 physical therapy sessions for the right shoulder, 2x/week for 6 weeks as an outpatient:
Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 200. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder Chapter, Physical Therapy.

Decision rationale: Regarding the request for additional physical therapy, Chronic Pain Medical Treatment Guidelines recommend a short course of active therapy with continuation of active therapies at home as an extension of the treatment process in order to maintain improvement levels. ODG has more specific criteria for the ongoing use of physical therapy. ODG recommends a trial of physical therapy. If the trial of physical therapy results in objective functional improvement, as well as ongoing objective treatment goals, then additional therapy may be considered. Within the documentation available for review, there is documentation of completion of prior PT sessions, but there is no documentation of specific objective functional improvement with the previous sessions and remaining deficits that cannot be addressed within the context of an independent home exercise program, yet are expected to improve with formal supervised therapy. Furthermore, the request exceeds the amount of PT recommended by the CA MTUS for rotator cuff impingement and, unfortunately, there is no provision for modification of the current request. In light of the above issues, the currently requested additional physical therapy is not medically necessary.