

Case Number:	CM15-0165201		
Date Assigned:	09/02/2015	Date of Injury:	06/20/2014
Decision Date:	10/06/2015	UR Denial Date:	08/18/2015
Priority:	Standard	Application Received:	08/24/2015

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 55 year old female who sustained an industrial injury to her left shoulder on 06-20-2014. The injured worker was diagnosed with rotator cuff tear and has a history of fibromyalgia. The injured worker is status post left rotator cuff repair on December 26, 2014. Treatment to date has included diagnostic testing, conservative measures, surgery, physical therapy (completed 20 out of 24 per the PT note on June 17, 2015), home exercise program and medications. According to the primary treating physician's progress report on June 3, 2015, the injured worker reported her left shoulder pain had slight improvement with more strength and mobility but continues to be unable to lift heavy objects. The injured worker rated her pain at 4-6 out of 10 on the pain scale. Examination demonstrated tenderness over the anterior shoulder without swelling. The left shoulder was noted to be stable with sensation to light touch and deep tendon reflexes of the bilateral upper extremity intact. Range of motion was documented as forward flexion at 90 degrees and abduction at 100 degrees. There was tenderness associated with resisted shoulder abduction and flexion and weakness with resisted extension rotation. The cervical spine range of motion was full with mild tenderness on the left trapezius and negative Spurling's. Current medications were listed as Norco, Dilaudid and Flexeril. Treatment plan consists of ice and heat treatment, home exercise program, return to work with modified duties and the current request for additional physical therapy (6 sessions).

IMR ISSUES, DECISIONS AND RATIONALES

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

Additional Physical Therapy two (2) times a week for three (3) weeks: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints, Chronic Pain Treatment Guidelines.

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

Decision rationale: 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 2014 injury with arthroscopic surgery over 9 months past. 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 Additional Physical Therapy two (2) times a week for three (3) weeks is not medically necessary and appropriate.