

Case Number:	CM15-0181032		
Date Assigned:	09/22/2015	Date of Injury:	03/11/2015
Decision Date:	10/27/2015	UR Denial Date:	08/26/2015
Priority:	Standard	Application Received:	09/14/2015

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: Iowa, Illinois, California

Certification(s)/Specialty: Preventive Medicine, Occupational Medicine, Public Health & General Preventive 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 53 year old female, who sustained an industrial-work injury on 3-11-15. She reported initial complaints of left shoulder pain. The injured worker was diagnosed as having left shoulder joint pain and left shoulder fracture. Treatment to date has included physical therapy, sling, and diagnostics. Currently, the injured worker complains of left shoulder pain described as dull to sharp and rated 2-3 out of 10. She feels the pain is a little better. She does not take pain medication. Per the primary physician's progress report (PR-2) on 8-10-15, exam noted non-antalgic gait, positive tenderness to the left shoulder over anterior cruciate ligament (ACL), biceps groove, and lateral shoulder. There was limited range of motion, normal sensation, resistance with shoulder abduction and flexion. The cervical spine had full range of motion, and negative Spurling's test. The Request for Authorization date was 8-14-15 and requested service to include Physical Therapy re-evaluation left shoulder per 8/10/2015 order and Physical Therapy twice weekly for the left shoulder, per 8/10/2015 order QTY: 6. The Utilization Review on 8-26-15 denied the request due to lack of documentation of prior functional benefit from therapy received or number of sessions received per date, per CA MTUS (California Medical Treatment Utilization Schedule) Physical Medicine Guidelines.

IMR ISSUES, DECISIONS AND RATIONALES

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

Physical Therapy re-evaluation left shoulder per 8/10/2015 order: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Physical Medicine. Decision based on Non-MTUS Citation Shoulder (Acute & Chronic), Physical Therapy, ODG Preface - Physical Therapy.

Decision rationale: California MTUS guidelines refer to physical medicine guidelines for physical therapy. "Allow for fading of treatment frequency (from up to 3 visits per week to 1 or less), plus active self-directed home physical medicine." Regarding physical therapy, ODG states "Patients should be formally assessed after a "six-visit clinical trial" to see if the patient is moving in a positive direction, no direction, or a negative direction (prior to continuing with the physical therapy); & (6) When treatment duration and/or number of visits exceeds the guideline, exceptional factors should be noted." At the conclusion of this trial, additional treatment would be assessed based upon documented objective, functional improvement, and appropriate goals for the additional treatment. The medical documentation provided indicates this patient has had an unknown number of physical therapy sessions. The treating physician has not provided documentation of objective functional improvement from the previous therapy to warrant additional treatment. As such, the request for physical therapy re-evaluation left shoulder per 8/10/2015 order is not medically necessary.

Physical Therapy twice weekly for the left shoulder, per 8/10/2015 order QTY: 6: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Physical Medicine. Decision based on Non-MTUS Citation Shoulder (Acute & Chronic), Physical Therapy, ODG Preface - Physical Therapy.

Decision rationale: California MTUS guidelines refer to physical medicine guidelines for physical therapy. "Allow for fading of treatment frequency (from up to 3 visits per week to 1 or less), plus active self-directed home physical medicine." Regarding physical therapy, ODG states "Patients should be formally assessed after a "six-visit clinical trial" to see if the patient is moving in a positive direction, no direction, or a negative direction (prior to continuing with the physical therapy); & (6) When treatment duration and/or number of visits exceeds the guideline, exceptional factors should be noted." The medical documentation provided indicates this patient has had an unknown number of physical therapy sessions. The treating physician has not provided documentation of objective functional improvement from the previous therapy to warrant additional treatment. As such, the request for physical therapy twice weekly for the left shoulder, per 8/10/2015 order qty: 6 is not medically necessary.