

Case Number:	CM15-0185333		
Date Assigned:	09/25/2015	Date of Injury:	06/10/2015
Decision Date:	11/06/2015	UR Denial Date:	08/24/2015
Priority:	Standard	Application Received:	09/21/2015

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, Texas, Florida

Certification(s)/Specialty: Anesthesiology, Pain Management, Hospice & Palliative 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 66 year old female, who sustained an industrial injury on 06-10-2015. A review of the medical records indicates that the injured worker (IW) is undergoing treatment for left rotator cuff syndrome and tendinitis of the left shoulder. Medical records (08-20-2015) indicate ongoing intermittent left shoulder pain with radiation to the left arm. Pain levels were 6-7 out of 10 on a visual analog scale (VAS) and reported to be worse with overhead movements and partially relieved with ice, Aleve and rest. The IW reported one episode of numbness in the left arm, and popping. Records also indicate IW has difficulty with washing hair, doing laundry and activities of daily living. Per the treating physician's progress report (PR), the IW has been released to work modified duty with restrictions. The physical exam of the left shoulder, dated 08-20-2015, revealed generalized tenderness over the left shoulder, limited range of motion with flexion 150°, abduction 100°, external rotation 40° and internal rotation 30° due to pain, motor strength and sensation were normal and intact, and special testing included a positive Hawkin's and Speed's tests, and supraspinatus produces pain. Relevant treatments have included 12 physical therapy (PT) sessions for the left shoulder, work restrictions, and pain medications. Physical therapy records were not available for review. The treating physician indicates that x-rays of the left shoulder (06-2015) showed normal alignment without fractures, no significant joint disease, and no significant soft tissue abnormality. The request for authorization (08-20-2015) shows that the following therapy was requested: 6 additional physical therapy sessions (2x3) for the left shoulder. The original utilization review (08-24-2015) non-certified the request for 6 additional physical therapy sessions (2x3) for the left shoulder.

IMR ISSUES, DECISIONS AND RATIONALES

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

Additional physical therapy 2 times a week for 3 weeks, 6 total for left shoulder: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Shoulder, Physical Therapy Guidelines.

MAXIMUS guideline: Decision based on MTUS Shoulder Complaints 2004, Section(s): General Approach, Initial Assessment, Medical History, Physical Examination, Diagnostic Criteria, Work-Relatedness, Initial Care, Activity Modification, Work Activities, Follow-up Visits, and Chronic Pain Medical Treatment 2009, Section(s): Physical Medicine. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder Chapter, Physical Therapy.

Decision rationale: Regarding the request for Additional physical therapy 2 times a week for 3 weeks, 6 total for left shoulder, 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 and, unfortunately, there is no provision for modification of the current request. In light of the above issues, the currently requested Additional physical therapy 2 times a week for 3 weeks, 6 total for left shoulder is not medically necessary.