

Case Number:	CM15-0189896		
Date Assigned:	10/02/2015	Date of Injury:	02/09/2012
Decision Date:	11/09/2015	UR Denial Date:	09/09/2015
Priority:	Standard	Application Received:	09/28/2015

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 34 year old male, who sustained an industrial injury on 2-9-2012. The injured worker is undergoing treatment for: right upper extremity, neck, right shoulder, right wrist and elbow. On 8-26-15, he reported pain to the right shoulder, right elbow, low back, middle back, right middle finger, and left wrist. Objective findings revealed a painful and decreased cervical spine range of motion, painful and decreased thoracic and lumbar spine ranges of motion, painful and decreased right shoulder and right wrist ranges of motion, and tenderness to the right elbow. The treatment and diagnostic testing to date has included: magnetic resonance imaging of the right elbow (date unclear), multiple sessions of physical therapy, TENS unit, and splinting, right distal biceps tendon rupture repair (date unclear), right wrist carpal tunnel release (June 2015). Current work status: not documented. The request for authorization is for: physical therapy 2 times a week for 6 weeks for the right shoulder. The UR dated 9-9-2015: non-certified the request for physical therapy 2 times a week for 6 weeks for the right shoulder.

IMR ISSUES, DECISIONS AND RATIONALES

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

Physical therapy 2 times a week for 6 weeks, right shoulder: Upheld

Claims Administrator guideline: Decision based on MTUS Shoulder Complaints 2004, and Postsurgical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Physical Medicine.

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 February 2012 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 2 times a week for 6 weeks, right shoulder is not medically necessary and appropriate.