

Case Number:	CM15-0194630		
Date Assigned:	10/08/2015	Date of Injury:	07/16/2013
Decision Date:	11/16/2015	UR Denial Date:	09/08/2015
Priority:	Standard	Application Received:	10/05/2015

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 42 year old male, who sustained an industrial injury on 7-16-2013. Medical records indicate the worker is undergoing treatment for left shoulder mini-arthroscopic and mini open surgery on the left shoulder, cervicgia, shoulder pain and myofascial pain-myalgia. A recent progress report dated 9-1-2015, reported the injured worker complained of left shoulder pain rated 7 out of 10. Physical examination revealed tenderness along the para spinous muscles of the neck and trapezius muscle, no impingement signs and healed wounds. Treatment to date has included TENS (transcutaneous electrical nerve stimulation), unknown number of physical therapy visits and medication management. The physician is requesting Additional Post-Operative Physical Therapy 2x6 Left Shoulder and Physical Therapy 2x6 Cervical Spine. On 9-8-2015, the Utilization Review noncertified the request for Additional Post-Operative Physical Therapy 2x6 Left Shoulder and Physical Therapy 2x6 Cervical Spine.

IMR ISSUES, DECISIONS AND RATIONALES

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

Additional Post Operative Physical Therapy 2x6 Left Shoulder: Upheld

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

MAXIMUS guideline: Decision based on MTUS Postsurgical Treatment 2009, Section(s): Shoulder.

Decision rationale: Review indicates the patient is s/p mini-open shoulder surgery with tenodesis of bicep tendon and debridement of subacromial space in July 2015 with postop PT visits. Recent report noted clinical exam findings of full shoulder range of motion in elevation with symmetrical internal and external movement and no impingement or apprehension signs. The Chronic Pain Guidelines allow for physical therapy with fading of treatment to an independent self-directed home program. The employee has received postop PT visits without specific demonstrated clinical deficits or functional limitations to allow for additional therapy treatments. Post-surgical guidelines allow for postop PT visits post surgical repair over a specified rehab period. The patient is without tenderness, has full shoulder range with good motor strength and negative orthopedic testing to support further therapy as the patient should have been transitioned to an independent home exercise program. There is no ADL limitations noted or extenuating circumstances to allow for further therapy outside guidelines criteria. The additional post operative physical therapy 2x6 Left Shoulder is not medically necessary and appropriate.

Physical Therapy 2x6 Cervical Spine: Upheld

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

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

Decision rationale: Time-limited care plan with specific defined goals, assessment of functional benefit with modification of ongoing treatment based upon the patient's progress in meeting those goals and the provider's continued monitoring of successful outcome is stressed by MTUS guidelines. 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. Submitted reports have no acute flare-up or specific physical limitations to support for physical/ occupational therapy. The Chronic Pain Guidelines allow for 9-10 visits of therapy with fading of treatment to an independent self-directed home program. It is unclear how many PT sessions have been completed; however, the submitted reports have not identified clear specific functional improvement in ADLs, functional status, or decrease in medication and medical utilization nor have there been a change in neurological compromise or red-flag findings demonstrated from the formal physical therapy already rendered to support further treatment. Submitted reports have also not adequately demonstrated the indication to support for excessive quantity of PT sessions without extenuating circumstances established beyond the guidelines for this 2013 injury. The physical therapy 2x6 cervical spine is not medically necessary and appropriate.