

| | | | |
|-----------------------|--------------|------------------------------|------------|
| Case Number: | CM15-0195878 | | |
| Date Assigned: | 10/09/2015 | Date of Injury: | 12/30/2010 |
| Decision Date: | 11/18/2015 | UR Denial Date: | 09/14/2015 |
| 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 61-year-old female who sustained an industrial injury on 12-30-2010. Diagnoses related to this request have included cervicothoracic strain-arthrosis with possible neural encroachment and possible right shoulder rotator cuff tear. The physician stated 9-2-2015 the injured worker has never had an MRI for these injuries. Documented treatment includes right shoulder injection "in the past" helping "significantly," she has been treated with anti-inflammatory medication but has stomach-related side effects, and the physician stated she has never had physical therapy for the cervical spine and right shoulder. On 9-1-2015, the injured worker reported a recurrence of pain in her neck and right shoulder. The objective examination revealed positive Spurling's and foraminal compression tests on the right side, and pain went as far as the elbow. Forward flexion of her right shoulder is noted to have caused significant pain; she had a positive Hawkins test, and full active assistive range of motion. The physician noted supraspinatus weakness but no pain with forward flexion to the left shoulder. The treating physician's plan of care includes 12 sessions of physical therapy for the neck and right shoulder, but this was denied on 9-14-2015. Current work status is not provided.

IMR ISSUES, DECISIONS AND RATIONALES

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

Physical therapy 3 times a week for 4 weeks to cervical and right shoulder: Upheld

Claims Administrator guideline: Decision based on MTUS Neck and Upper Back Complaints 2004, Section(s): Summary, and Shoulder Complaints 2004, Section(s): Summary. Decision based on Non-MTUS Citation Official Disability Guidelines - Treatment for Workers' Compensation (ODG-TWC) Online Edition, 2015 Chapter: Neck and Upper Back (Acute & Chronic); ODG, Introduction, Physical Therapy.

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 2010 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 3 times a week for 4 weeks to cervical and right shoulder is not medically necessary and appropriate.