

Case Number:	CM15-0207326		
Date Assigned:	10/26/2015	Date of Injury:	08/29/2011
Decision Date:	12/07/2015	UR Denial Date:	09/28/2015
Priority:	Standard	Application Received:	10/21/2015

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

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 41 year old female with a date of injury on 08-29-2011. The injured worker is undergoing treatment for left shoulder bursitis and left acromioclavicular joint, bilateral knee strain and bilateral ankle strain. A physical therapy progress note, #4 session, dated 09-10-2015 documents the injured worker has continued severe pain to his left shoulder. He has pain to his cervical spine into the trapezius and periscapular area. He has complaints of multiple trigger points. Active range of motion shows decreased forward flexion. He has severe pain in all passive ranges of motion. Several documents within the submitted medical records are difficult to decipher. He received 6 previous physical sessions for the left shoulder in June of this year. Treatment to date has included diagnostic studies, medications, physical therapy and corticosteroid injections and a recent Functional Restoration Program on 08-26-2015, home exercises and stretches. A Magnetic Resonance Imaging of the left shoulder done on 05-13-2015 reveals mild tendinosis of the left supraspinatus tendon, minimal subchondral edema in the distal end of the left clavicle, down sloping of the left acromion and a small amount of fluid in the left subacromial subdeltoid bursa which may represent bursitis, small left glenohumeral joint effusion. The Request for Authorization dated 09-18-2015 includes Physical therapy 2 times a week for 4 weeks for left shoulder. On 09-28-2015 Utilization Review modified the request for Physical therapy 2 times a week for 4 weeks for left shoulder to physical therapy 6 visits for the left 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 4 weeks 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 Chapter, Physical Therapy Guidelines.

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

Decision rationale: Review indicates treatment to date has included diagnostic studies, medications, physical therapy, corticosteroid injections, recent Functional Restoration Program (FRP) on 08-26-2015, home exercises and stretches. The request for PT was modified to 6 sessions. 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 total 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 from the formal physical therapy already rendered to support further treatment. There has not been a change in neurological compromise or red- flag findings demonstrated for PT at this time. Submitted reports have also not adequately identified the indication to support for excessive quantity of PT sessions without extenuating circumstances established beyond the guidelines. The Physical therapy 2 times a week for 4 weeks for left shoulder is not medically necessary and appropriate.