

Case Number:	CM15-0025667		
Date Assigned:	02/18/2015	Date of Injury:	03/10/2006
Decision Date:	12/03/2015	UR Denial Date:	02/06/2015
Priority:	Standard	Application Received:	02/10/2015

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: Ohio, West Virginia

Certification(s)/Specialty: Preventive Medicine, Occupational Medicine, Medical Toxicology

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 45 year old female injured worker suffered an industrial injury on 3-10-2006. The diagnoses included shoulder joint pain, lumbosacral disc degeneration, and neck pain. On 1-30-2015, the treating provider reported chronic upper extremity pain in the left shoulder and Tramadol had been effective for pain relief. On exam, the left rotator cuff muscles were weak and had a positive drop arm test. The therapy request was to improve strength of the shoulder stabilizing the muscles. Prior treatment included left rotator cuff repair 4 to 5 years ago. The Utilization Review on 2-6-2015 determined non-certification for Physical Therapy (Left Shoulder) 1 Time a Week for 12 Weeks.

IMR ISSUES, DECISIONS AND RATIONALES

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

Physical Therapy (Left Shoulder) 1 Time A Week for 12 Weeks: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Shoulder Complaints 2004, Section(s): Initial Care. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder (Acute & Chronic), Physical therapy.

Decision rationale: California MTUS guidelines refer to physical medicine guidelines for physical therapy. "Allow for fading of treatment frequency (from up to 3 visits per week to 1 or less), plus active self-directed home Physical Medicine." Regarding physical therapy, ODG states "Patients should be formally assessed after a 'six-visit clinical trial' to see if the patient is moving in a positive direction, no direction, or a negative direction (prior to continuing with the physical therapy); & (6) When treatment duration and/or number of visits exceeds the guideline, exceptional factors should be noted." At the conclusion of this trial, additional treatment would be assessed based upon documented objective, functional improvement, and appropriate goals for the additional treatment. The available medical record notes prior physical therapy for this shoulder in 2011 but given the time since the last session, this request must be considered a new request. The request for 12 sessions is in excess of the initial trials per MTUS and ODG guidelines. As such, the request for physical therapy (left shoulder) 1 time a week for 12 weeks is not medically necessary.