

Case Number:	CM14-0017351		
Date Assigned:	04/14/2014	Date of Injury:	10/08/2008
Decision Date:	05/30/2014	UR Denial Date:	01/13/2014
Priority:	Standard	Application Received:	02/11/2014

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. The expert reviewer is Board Certified in Physical Medicine and Rehabilitation, and is licensed to practice in Illinois. 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

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 54-year-old male who reported an injury on 10/8/08. The mechanism of injury was not provided for review. The current diagnosis is a labral tear. The most recent physician's progress report submitted for review is dated 9/10/13. The injured worker was status post left shoulder arthroscopy with manipulation under anesthesia. The injured worker has completed a course of physical therapy. Physical examination revealed mild tenderness to palpation in the pectoralis muscle, tenderness over the acromion and bicipital groove, limited shoulder range of motion, and normal rotator cuff strength. Treatment recommendations included physical therapy twice per week for four weeks.

IMR ISSUES, DECISIONS AND RATIONALES

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

PHYSICAL THERAPY, TWICE A WEEK FOR FOUR WEEKS FOR THE RIGHT SHOULDER: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 7, 98-99.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 98-99.

Decision rationale: The California MTUS guidelines state that active therapy is based on the philosophy that therapeutic exercise and/or activity are beneficial for restoring flexibility, strength, endurance, function, and range of motion. It can also alleviate discomfort. The injured worker has completed a previous course of physical therapy. However, there was no documentation of objective functional improvement. There was also no evidence of a significant musculoskeletal or neurological deficit with regard to the right upper extremity. Based on the clinical information received, the request is not medically necessary.