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| Case Number: | CM14-0116851 | | |
| Date Assigned: | 09/16/2014 | Date of Injury: | 12/17/2002 |
| Decision Date: | 11/20/2014 | UR Denial Date: | 06/26/2014 |
| Priority: | Standard | Application Received: | 07/25/2014 |

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 California. 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:

This 66 year-old patient sustained an injury on 12/17/2002 while employed by [REDACTED]. Request(s) under consideration include Physical Therapy to left shoulder (3X6) 18 sessions. Last surgery was almost 8 years past. Diagnoses include shoulder impingement and rotator cuff tendonitis. Past surgical history include s/p left shoulder rotator cuff repair December 2003; MUA in April 2004; s/p right shoulder rotator cuff repair in October 2004; MUA in October 2005; and s/p right rotator cuff repair, Mumford procedure, acromioplasty on 1/29/07. Conservative care has included medications, physical therapy, steroid injections, and modified activities/rest. Report of 10/15/13 from the provider noted chronic ongoing shoulder pain with exam findings of limited abduction and positive impingement signs with recommendation for PT. Report of 6/5/14 from the provider noted the patient with bilateral shoulder pain and weakness. Exam showed shoulders with tenderness to palpation, limited range, positive impingement testing; and limited range with 90 degrees elevation, full internal rotation. A steroid injection was provided with treatment plan for physical therapy and refill of medications. The request(s) for Physical Therapy to left shoulder (3X6) 18 sessions was modified for 2 sessions on 6/26/14 citing guidelines criteria and lack of medical necessity.

IMR ISSUES, DECISIONS AND RATIONALES

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

Physical Therapy to left shoulder (3X6) 18 sessions: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines physical medicine.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Guidelines -Allow for fading of treatment frequency (from up to 3 visits per.

Decision rationale: This 66 year-old patient sustained an injury on 12/17/2002 while employed by [REDACTED]. Request(s) under consideration include Physical Therapy to left shoulder (3X6) 18 sessions. Last surgery was almost 8 years past. Diagnoses include shoulder impingement and rotator cuff tendonitis. Past surgical history include s/p left shoulder rotator cuff repair December 2003; MUA in April 2004; s/p right shoulder rotator cuff repair in October 2004; MUA in October 2005; and s/p right rotator cuff repair, Mumford procedure, acromioplasty on 1/29/07. Conservative care has included medications, physical therapy, steroid injections, and modified activities/rest. Report of 10/15/13 from the provider noted chronic ongoing shoulder pain with exam findings of limited abduction and positive impingement signs with recommendation for PT. Report of 6/5/14 from the provider noted the patient with bilateral shoulder pain and weakness. Exam showed shoulders with tenderness to palpation, limited range, positive impingement testing; and limited range with 90 degrees elevation, full internal rotation. A steroid injection was provided with treatment plan for physical therapy and refill of medications. The request(s) for Physical Therapy to left shoulder (3X6) 18 sessions was modified for 2 sessions on 6/26/14. 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 work 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 9-10 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 2002 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 to left shoulder (3X6) 18 sessions is not medically necessary and appropriate.