

Case Number:	CM14-0119332		
Date Assigned:	09/16/2014	Date of Injury:	12/23/2009
Decision Date:	10/16/2014	UR Denial Date:	07/03/2014
Priority:	Standard	Application Received:	07/28/2014

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 Texas. 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:

Medical records reflect the claimant is a 56 year old male who sustained a work injury on 12-23-09. Medical Records reflect the claimant had a history of rotator cuff repair. The MRI of the left shoulder dated 6-5-14 showed acromioplasty changes. Status post supraspinatus rotator cuff repair. There is partial articular surface tear of het reconstructed supraspinatus tendon. No full thickness tears seen. There is no evidence of labral pathology. The biceps tendon and biceps tendons attachments are normal. There are mild biceps tenosynovitis changes. The claimant underwent a physical therapy evaluation on 6-17-14. Office visit on 9-2-14 notes the claimant has left shoulder pain, low back pain, and cervical spine pain. The MRI of the left shoulder was reviewed. It is noted the claimant has L4-L5 HNP and left knee arthrosis.

IMR ISSUES, DECISIONS AND RATIONALES

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

Physical therapy 2x6: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical medicine/therapy Page(s): 99.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Page(s): 98-99. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Shoulder, Physical Therapy

Decision rationale: Chronic Pain Medical Treatment Guidelines as well as ODG notes that one should allow for fading of treatment frequency (from up to 3 visits per week to 1 or less), plus active self-directed home Physical Medicine. There is an absence in documentation noting that this claimant cannot perform a home exercise program. There are no extenuating circumstances to support physical therapy at this juncture. Additionally, this is a nonspecific request, body areas not documented. Therefore, the medical necessity of this request is not established.