

Case Number:	CM14-0049235		
Date Assigned:	07/07/2014	Date of Injury:	06/15/2011
Decision Date:	08/25/2014	UR Denial Date:	03/17/2014
Priority:	Standard	Application Received:	04/17/2014

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 & 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 60-year-old male who reported an injury on 06/15/2011 caused by unspecified mechanism. The injured worker's treatment history included physical therapy, surgery, orthotic supplies, medications, and MRI. The injured worker was evaluated on 01/21/2014 and it was documented that the injured worker had decreased pain in the right shoulder with increased range of motion and states that his shoulder feels achy after therapy. He had increased pain in his left shoulder due to favoring the right shoulder and his left knee was about 80% of the normal range. The objective findings of the right shoulder revealed range of motion was 90% of normal range and muscle strength was 4/5. Diagnoses included right shoulder sprain/strain with rotator cuff tear, status post arthroscopic surgery, and left knee sprain/strain status post arthroscopic surgery. The provider noted the injured worker was undergoing physical therapy sessions; however, the outcome measurements were not submitted for this review. The request for authorization or rationale was not submitted for this review.

IMR ISSUES, DECISIONS AND RATIONALES

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

Physical therapy 2xwk x 6wks right shoulder: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 99. Decision based on Non-MTUS Citation Official Disability Guidelines: Shoulder Chapter.

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

Decision rationale: The requested is not medically necessary. The California MTUS Chronic Pain Medical Treatment Guideline recommends physical medicine of right shoulder up to a total of 9 to 10 visits over 8 weeks for myalgia and myositis, and 8 to 10 visits over 4 weeks for neuralgia, neuritis, and radiculitis. The diagnoses included right shoulder sprain/strain with rotator cuff tear, status post arthroscopic surgery and left knee sprain/strain, status post arthroscopic surgery. It was noted that the injured worker had prior sessions of physical therapy; however, there was lack of documentation provided on the outcome measure and functional improvement. There was lack of documentation on the injured worker's outcome of conservative care such as pain medication management or home exercise regimen. In addition the requested amount of visits will exceed recommended amount of visits per the guidelines. Furthermore, the documentation lacked the injured worker long-term goal for functional improvement. Given the above, request for physical therapy 2Xwk X wks for the right shoulder is not medically necessary.