

Case Number:	CM15-0122047		
Date Assigned:	07/06/2015	Date of Injury:	04/02/2014
Decision Date:	07/31/2015	UR Denial Date:	06/04/2015
Priority:	Standard	Application Received:	06/24/2015

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: California
 Certification(s)/Specialty: Physical Medicine & Rehabilitation

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 (IW) is a 60 year old male who sustained an industrial injury on 04/02/2014. The mechanism of injury and initial report of injury are not found in the records reviewed. The injured worker was diagnosed as having right shoulder bicipital tendinitis. Treatment to date has included right rotator cuff repair on 10/08/2014. Currently, the injured worker is seen in follow up for the right shoulder and low back. He complains of ache in the shoulder with slight difficulty in motion but is felt to be progressing normally. On physical exam the shoulder has about 160 degrees of abduction. There is tenderness to palpation anteriorlaterally. Cuff strength is improving. He is elevating the shoulder with forward flexion and abduction and has scapular dyskinesia. Treatment plans include an epidural injection, and physical therapy. A request for authorization is made for the following: Physical therapy, 2 times a week for 3 weeks, right shoulder QTY: 6 per 5/14/15 order.

IMR ISSUES, DECISIONS AND RATIONALES

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

Physical therapy, 2 times a week for 3 weeks, right shoulder QTY: 6 per 5/14/15 order:
 Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Therapy, pages 98-99.

Decision rationale: The patient is almost 10 months post arthroscopy and chronic guidelines are applicable. Submitted reports have no acute flare-up or specific physical limitations to support for physical/ occupational therapy. 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. There is unchanged chronic symptom complaints, clinical findings, and functional status. There is no evidence documenting functional baseline with clear goals to be reached and the patient striving to reach those goals. It is unclear how many PT/OT sessions the patient has received or what functional outcome was benefited if any. The Chronic Pain Guidelines allow for visits of therapy with fading of treatment to an independent self-directed home program. It appears the patient has received prior sessions of PT/OT without clear specific functional improvement in ADLs, functional status, or decrease in medication and utilization without change in neurological compromise or red-flag findings to support further treatment. The Physical therapy, 2 times a week for 3 weeks, right shoulder QTY: 6 per 5/14/15 order is not medically necessary and appropriate.