

Case Number:	CM15-0174933		
Date Assigned:	09/16/2015	Date of Injury:	08/18/2014
Decision Date:	10/19/2015	UR Denial Date:	08/11/2015
Priority:	Standard	Application Received:	09/04/2015

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, Indiana, New York
Certification(s)/Specialty: Internal Medicine

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 53 year old male who sustained an industrial injury on 8-18-14. He had complaints of left shoulder pain. Treatments include: medication, physical therapy, and surgery. Progress report dated 8-4-15 reports continued complaints of left shoulder pain. The pain is rated 4 out of 10 and is aggravated by reaching, lifting, carrying, and washing his hair, the pain increases after 5 minutes and remains increased for the next 2 hours. Diagnoses include: left shoulder bursae and tendons disorder, left shoulder weakness, left shoulder joint pain, left shoulder contracture joint, left shoulder ankylosis of joint, and left shoulder rotator cuff sprain. Plan of care includes: physical therapy 3 times per week for 4 weeks, therapeutic exercise; stretching, soft tissue mobilization techniques, self care, and resistive activities; isometric, machines, free weights, tubing and bands. Work status: unable to return to work secondary to dysfunction.

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 6 weeks: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Physical Medicine. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder section, Physical therapy.

Decision rationale: Pursuant and to the Chronic Pain Medical Treatment Guidelines and the Official Disability Guidelines, physical therapy two times a week times six weeks is not medically necessary. Patients should be formally assessed after a six visit clinical trial to see if the patient is moving in a positive direction, no direction or negative direction (prior to continuing with physical therapy). When treatment duration and/or number of visits exceeds the guideline, exceptional factors should be noted. In this case, the injured worker's working diagnoses are status post manipulation under anesthesia; left rotator cuff repair and biceps tenodesis. The date of injury is August 18, 2012. Request for authorization is August 6, 2015. According to April 13, 2015 progress note, the injured worker is status post rotator cuff repair and biceps tenodesis. The injured worker had a manipulation under anesthesia April 13, 2015 within intra-articular and intra-capsular block. On May 20, 2015 12 physical therapy sessions were authorized. According to a physical therapy progress note dated August 14, 2015, the injured worker was on physical therapy session #11. The most recent progress note by the treating provider is dated June 26, 2015. Subjectively, the injured worker has continued post manipulation under anesthesia pain in the left shoulder 3/10. Objectively, there is decreased range of motion. According to the August 6, 2015 request for authorization, the treating provider is requesting additional physical therapy. There are no compelling clinical facts in the medical records indicating additional physical therapy over the recommended guidelines is clinically indicated. Additionally, there is no contemporaneous clinical documentation by the requesting provider on or about the date of request for authorization August 6, 2015. (The most recent progress note is dated June 26, 2015). Based on clinical information in the medical record, peer-reviewed evidence-based guidelines, no contemporaneous clinical documentation by the requesting provider on or about the date of request for authorization, and no compelling clinical documentation indicating additional physical therapy over the recommended guidelines is clinically indicated, physical therapy two times a week times six weeks is not medically necessary.