

Case Number:	CM15-0021051		
Date Assigned:	02/10/2015	Date of Injury:	01/07/2011
Decision Date:	07/07/2015	UR Denial Date:	01/21/2015
Priority:	Standard	Application Received:	02/03/2015

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:

This 61 year old male sustained an industrial injury to the left hip, left shoulder and left wrist on 1/2/11. Previous treatment included magnetic resonance imaging, physical therapy and medications. Magnetic resonance imaging lumbar spine (5/13/14) showed lumbar spondylolisthesis and lateral recess stenosis. Magnetic resonance imaging left wrist showed diastasis of the scapholunate joint. Magnetic resonance imaging left shoulder showed tendinitis of the rotator cuff and a humeral head cyst. Electromyography bilateral lower extremities (1/22/15) showed hereditary neuropathy. In the most recent PR-2 submitted for review, dated 1/27/15, the injured worker complained of pain to the left shoulder and right knee rated 5/10 on the visual analog scale. The injured worker reported that pain was made worse with repetitive use and prolonged standing and walking. Physical exam was remarkable for left shoulder with mild tenderness to palpation to the acromial region with decreased range of motion and right knee with cramping of the posterior thigh musculature with full flexion of the right knee. Current diagnoses included left shoulder rotator cuff tendinitis with impingement, left hip strain and right knee strain with evidence of fat pad edema. The treatment plan included a home exercise program.

IMR ISSUES, DECISIONS AND RATIONALES

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

Physical therapy 8 visits (2x/week x 4 weeks) to the left shoulder: Upheld

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

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 section, Physical therapy.

Decision rationale: Pursuant to the Chronic Pain Medical Treatment Guidelines and the Official Disability Guidelines, physical therapy eight visits (two times per week times four weeks) to the left shoulder 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 left shoulder rotator cuff tendinitis with impingement; right knee strain with evidence of fat pad edema (per MRI); and left hip strain. According to a progress note dated December 23, 2014 (request for authorization January 16, 2015), the injured worker received at least 23 sessions of prior physical therapy to the affected shoulder. There are no physical therapy progress notes the medical record. There is no documentation demonstrating objective functional improvement with prior physical therapy. Subjectively, the injured worker had increased pain in and about the left shoulder. Objectively, range of motion was limited to flexion 90, abduction 80 and external rotation 90. There was tenderness to palpation over the anterior aspect of the subacromial space. Strength was normal 5/5. Neurological examination showed normal sensation and decreased strength in the left shoulder. The treating provider requested additional physical therapy two times per week times four weeks. Consequently, absent clinical documentation with prior physical therapy progress notes, evidence of objective functional improvement and compelling clinical facts indicating additional physical therapy is warranted, physical therapy eight visits (two times per week times four weeks) to the left shoulder is not medically necessary.