MAXIMUS Federal Services

Case Number:	CM15-0097536		
Date Assigned:	05/28/2015	Date of Injury:	06/21/2014
Decision Date:	06/26/2015	UR Denial Date:	04/23/2015
Priority:	Standard	Application Received:	05/20/2015

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 is a 54-year-old male with an industrial injury dated 6/21/2014. The injured worker's diagnoses include right shoulder impingement syndrome, right shoulder labral tear, right supraspinatus/infraspinatus tear and right biceps tendon tear. Treatment consisted of diagnostic studies, prescribed medications, and periodic follow up visits. In the most recent progress note dated 2/2/2015, the injured worker reported left shoulder pain, decrease range of motion, weakness in the right upper extremity and hand numbness since surgery. Objective findings revealed right biceps intact, severe decrease range of motion in right shoulder, positive weakness and decrease active range of motion with pain, tenderness to palpitation over right subscapular, tenderness to palpitation of the anterior/ lateral rotator cuff footprint, and positive weakness with belly press. Some documents within the submitted medical records are difficult to decipher. The treating physician prescribed services for eight physical therapy visits for the lumbar spine and left shoulder now under review.

IMR ISSUES, DECISIONS AND RATIONALES

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

8 Physical therapy visits for the lumbar spine and left shoulder: Upheld

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

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

Decision rationale: Physical 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. However, there is no clear measurable evidence of progress with the PT treatment already rendered including milestones of increased ROM, strength, and functional capacity. Review of submitted physician reports show no evidence of functional benefit, 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. The Chronic Pain Guidelines allow for visits of physical therapy with fading of treatment to an independent self-directed home program. It appears the employee has received significant therapy sessions without demonstrated evidence of functional improvement to allow for additional therapy treatments. There is no report of acute flare-up, new injuries, or change in symptom or clinical findings to support for formal PT in a patient that has been instructed on a home exercise program for this chronic injury. Submitted reports have not adequately demonstrated the indication to support further physical therapy when prior treatment rendered has not resulted in any functional benefit. The 8 Physical therapy visits for the lumbar spine and left shoulder is not medically necessary or appropriate.