

Case Number:	CM15-0099729		
Date Assigned:	05/29/2015	Date of Injury:	04/10/2014
Decision Date:	07/08/2015	UR Denial Date:	05/14/2015
Priority:	Standard	Application Received:	05/26/2015

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: 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 29 year old male, who sustained an industrial injury on 10/4/14. The injured worker has complaints of right shoulder pain. The documentation noted on examination that the Spurling's test was positive and sensation was intact to light touch and there was decreased range of motion with abduction of the right shoulder. The diagnoses have included shoulder pain status post-surgery; impingement tendinitis and glenohumeral ligament laxity. Treatment to date has included right shoulder arthroscopic subacromial decompression with anterior acromioplasty, resection of coracoacromial ligament, and bursectomy and right shoulder glenohumeral arthroscopy with debridement and synovectomy on 12/5/14; physical therapy; magnetic resonance imaging (MRI) of the right upper extremity in May 2014 showed supraspinatus tendon with low grade bursal-sided partial thickness tearing of footprint anteriorly, non-acute appearing, no full thickness rotator cuff tendon tear on the anterior superior labrum like type 11 acromion with lateral down slopping; X-rays of the shoulder showed slight to mild downwards angulation of acromion and slightly limited internal external rotation view, but otherwise unremarkable; home exercise program and medications. The request was for 12 visits of physical therapy for the right shoulder.

IMR ISSUES, DECISIONS AND RATIONALES

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

12 visits of Physical Therapy for the Right Shoulder: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Therapy Page(s): 98.

Decision rationale: According to the California MTUS Treatment guidelines, physical therapy (PT) is indicated for the treatment of musculoskeletal pain. Recommendations state that for most patients with more severe and sub-acute low back pain conditions, 8 to 12 visits over a period of 6 to 8 weeks is indicated as long as functional improvement and program progression are documented. Active therapy is based on the philosophy that therapeutic exercise and/or activity are beneficial for restoring flexibility, strength, endurance, function, range of motion, and can alleviate discomfort. Patients are instructed and expected to continue active therapies at home as an extension of the treatment process in order to maintain improvement levels. Home exercise can include exercise with or without mechanical assistance or resistance and functional activities with assisting devices. In this case, the patient has completed physical therapy sessions. There is no documentation indicating that he had a defined functional improvement in his condition. There is no specific indication for the requested additional PT sessions. Medical necessity for the requested item has not been established. The requested item is not medically necessary.