

Case Number:	CM15-0099995		
Date Assigned:	06/02/2015	Date of Injury:	01/16/2008
Decision Date:	06/30/2015	UR Denial Date:	05/06/2015
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: Iowa, Illinois, Hawaii

Certification(s)/Specialty: Preventive Medicine, Occupational Medicine, Public Health & General Preventive 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 42 year old female, who sustained an industrial injury on January 16, 2008. She reported neck pain and left shoulder pain after a large box fell on her left side. The injured worker was diagnosed as having cervical degenerative disc disease, CRPS/neuropathic pain in the left arm, left shoulder pain and tendonopathy, new onset of right shoulder pain, pain in the limb and frozen left shoulder. Treatment to date has included diagnostic studies, functional restoration program (discontinued after one week), physical therapy, medications and work restrictions. Currently, the injured worker complains of right shoulder pain, neck and left shoulder pain radiating to the left elbow with associated occasional swelling of the left arm and a cold sensation of the left hand. The injured worker reported an industrial injury in 2008, resulting in the above noted pain. She was treated conservatively without complete resolution of the pain. Evaluation on January 22, 2015, revealed continued pain as noted. Evaluation on March 19, 2015, revealed continued pain as noted. Physical therapy for the left shoulder was requested.

IMR ISSUES, DECISIONS AND RATIONALES

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

Physical therapy for the left shoulder Qty: 12: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints, Chronic Pain Treatment Guidelines physical medicine. Decision based on Non-MTUS Citation Official Disability Guidelines-Treatment in Workers' Compensation, Shoulder Chapter (Acute and Chronic).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Therapy, Physical Medicine Page(s): 98-99. Decision based on Non-MTUS Citation Shoulder (Acute & Chronic), Physical Therapy, ODG Preface Physical Therapy.

Decision rationale: California MTUS guidelines refer to physical medicine guidelines for physical therapy. "Allow for fading of treatment frequency (from up to 3 visits per week to 1 or less), plus active self-directed home Physical Medicine." Regarding physical therapy, ODG states "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 a negative direction (prior to continuing with the physical therapy); & (6) When treatment duration and/or number of visits exceeds the guideline, exceptional factors should be noted." At the conclusion of this trial, additional treatment would be assessed based upon documented objective, functional improvement, and appropriate goals for the additional treatment. The medical documentation provided indicate this patient was approved for a 2 week functional restoration program, of which she only attended one week before removing herself. The treating physician has not provided documentation of objective functional improvement from the therapy that was provided during the functional restoration program. It is unclear if this patient has attended other PT in the past or the results of that therapy. If the patient has not participated in therapy, the request for 12 sessions is far in excess of the initial trials per MTUS and ODG guidelines. The request is also in excess of the 10 sessions guidelines recommend for acute exacerbation of a chronic shoulder injury. As such, the request for Physical therapy for the left shoulder Qty: 12 is not medically necessary at this time.