

Case Number:	CM13-0064790		
Date Assigned:	01/03/2014	Date of Injury:	02/24/2010
Decision Date:	05/28/2014	UR Denial Date:	11/12/2013
Priority:	Standard	Application Received:	12/12/2013

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. The expert reviewer is Board Certified in Physical Medicine & Rehabilitation and is licensed to practice in California. 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

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 is a 31 year old female patient with a 1/10/13 date of injury. She has been suffering from chronic cervical pain, thoracic pain, lumbar pain, and right knee pain. Review of notes consistently identifies that the patient suffers from cervical, right knee, and lumbar complaints. She has been treated with chiropractic manipulation for these complaints. In addition, the therapy has been augmented with work conditioning/functional restoration. The notes from these sessions are not included. 10/28/13 note states that the patient has frequent moderate right knee pain. Medication and chiropractic therapy have helped to increase ADLs. Objectively, there is a right knee exam demonstrating functional limitations.

IMR ISSUES, DECISIONS AND RATIONALES

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

PHYSICAL THERAPY TWICE A WEEK FOR FIVE WEEKS FOR THE LEFT SHOULDER: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM, Chronic Pain Treatment Guidelines.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation MTUS: CHRONIC PAIN MEDICAL TREATMENT GUIDELINES 2009, PHYSICAL MEDICINE, 98-99

Decision rationale: CA MTUS Chronic Pain Medical Treatment Guidelines state that Passive therapy (those treatment modalities that do not require energy expenditure on the part of the patient) can provide short term relief during the early phases of pain treatment and are directed at controlling symptoms such as pain, inflammation and swelling and to improve the rate of healing soft tissue injuries. They can be used sparingly with active therapies to help control swelling, pain and inflammation during the rehabilitation process. 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. Active therapy requires an internal effort by the individual to complete a specific exercise or task. This form of therapy may require supervision from a therapist or medical provider such as verbal, visual and/or tactile instruction(s). Patients are instructed and expected to continue active therapies at home as an extension of the treatment process in order to maintain improvement levels. However, the patient's left shoulder complaints are not clearly delineated. Previous treatment directed at the left shoulder is not entirely clear. The request is not medically necessary.