

Case Number:	CM13-0071210		
Date Assigned:	01/08/2014	Date of Injury:	10/07/2011
Decision Date:	03/27/2014	UR Denial Date:	12/02/2013
Priority:	Standard	Application Received:	12/26/2013

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Orthopedic Surgery, and is licensed to practice in Texas. 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 physician 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:

The patient is a 37-year-old male who reported an injury on 10/07/2011. The mechanism of injury was not specifically stated. The patient is currently diagnosed with tendonitis, shoulder impingement, acromioclavicular joint cartilage disorder, subacromial bursitis, partial rotator cuff tear, pain in the left shoulder, cervical musculoligamentous sprain, left knee sprain, left knee tendinosis, meniscal degeneration, status post left shoulder arthroscopy, major depressive disorder, and generalized anxiety disorder. The patient was seen by [REDACTED] on 11/07/2013. The patient reported persistent 7/10 pain. Physical examination revealed tenderness along the medial and lateral joint line of the left knee with positive McMurray's testing, tenderness along the left deltoid, trapezium, and left AC joint, and diminished left knee range of motion. Treatment recommendations included additional chiropractic and physical therapy 3 times per week for 4 weeks.

IMR ISSUES, DECISIONS AND RATIONALES

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

Chiro/Physiotherapy x 12 left shoulder: Upheld

Claims Administrator guideline: Decision based on MTUS Postsurgical Treatment Guidelines Page(s): 25.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 58 and 98-99.

Decision rationale: California MTUS Guidelines state manual therapy and manipulation is recommended for chronic pain if caused by a musculoskeletal condition. Treatment for the upper extremity is not recommended. The patient has previously participated in chiropractic treatment. Documentation of the previous course of treatment with total duration and efficacy was not provided. With regard to additional physical therapy, California MTUS Guidelines state 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. Guidelines allow for a fading of treatment frequency, plus active self-directed home physical medicine. The patient has completed an extensive amount of postoperative physical therapy. Documentation of objective measurable improvement was not provided. Despite ongoing therapy, the patient continued to report high levels of pain. Based on the clinical information received and the California MTUS Guidelines, the request is non-certified.