

Case Number:	CM15-0012744		
Date Assigned:	02/26/2015	Date of Injury:	02/13/2012
Decision Date:	04/02/2015	UR Denial Date:	01/15/2015
Priority:	Standard	Application Received:	01/21/2015

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: Emergency 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 36 year old female, who sustained an industrial injury on 2/13/12. The injured worker has complaints of left shoulder pain. She has nocturnal symptoms of left shoulder pain that often awaken her; left shoulder pain whenever she is lifting her arm up; left shoulder pain when reaching and certain activities such as using a blow dryer with her left arm are painful. The diagnoses have included status post left shoulder arthroscopic rotator cuff repair with subacromial decompression and acromioplasty and extensive debridement of the glenohumeral joint on 3/18/14; symptomatic left shoulder high grade partial suprapinatus tendon tear and status post left wrist arthroscopic synovectomy, triangular fibrocartilage complex debridement, dorsal capsulectomy and ganglionectomy on May 29, 2013. Magnetic Resonance Imaging (MRI) with arthrogram of the left shoulder, from October 23, 2014 was performed full thickness tear of the volar component of the scapholunate ligament with intact dorsal and membranous components, According to the utilization review performed on 1/15/15, the requested Physical Therapy 2x6 C/S has been modified to Physical Therapy 2x2 C/S and the requested 9 Chiropractic Visits over 8 weeks C/S has been non-certified. Physical Medicine Guidelines were used in the utilization review.

IMR ISSUES, DECISIONS AND RATIONALES

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

Physical Therapy 2x6 C/S: Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 181. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Neck and Upper Back, Acute and Chronic, Physical therapy.

Decision rationale: The requested Physical Therapy 2x6 C/S is not medically necessary. American College of Occupational and Environmental Medicine (ACOEM), 2nd Edition, (2004), CHAPTER 8, Neck and Upper Back Complaints, Summary of Recommendations and Evidence, Page 181; and Official Disability Guidelines (ODG), Neck and Upper Back, Acute and Chronic, Physical therapy, recommend continued physical therapy with documented objective evidence of derived functional benefit. The injured worker has left shoulder pain. She has nocturnal symptoms of left shoulder pain that often awaken her; left shoulder pain whenever she is lifting her arm up; left shoulder pain when reaching and certain activities such as using a blow dryer with her left arm are painful. The treating physician has not documented the medical necessity for current trial of physical therapy beyond the referenced guideline recommendations for a trial of therapy with subsequent re-evaluation of derived functional improvement. The criteria noted above not having been met, Physical Therapy 2x6 C/S is not medically necessary.

9 Chiropractic Visits over 8 weeks C/S: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 58-59.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Manual Therapy and Manipulation, Pages 58-59 Page(s): 58-59.

Decision rationale: The requested 9 Chiropractic Visits over 8 weeks C/S, is not medically necessary. CA MTUS Chronic Pain Treatment Guidelines, Manual Therapy and Manipulation, Pages 58-59, recommend continued chiropractic therapy with documented objective evidence of derived functional benefit. The injured worker has left shoulder pain. She has nocturnal symptoms of left shoulder pain that often awaken her; left shoulder pain whenever she is lifting her arm up; left shoulder pain when reaching and certain activities such as using a blow dryer with her left arm are painful. The treating physician has not documented the medical necessity for chiropractic concurrently with a trial of physical therapy. The criteria noted above not having been met, 9 Chiropractic Visits over 8 weeks C/S is not medically necessary.