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| Case Number: | CM13-0043021 | | |
| Date Assigned: | 12/27/2013 | Date of Injury: | 09/10/2009 |
| Decision Date: | 05/02/2014 | UR Denial Date: | 10/16/2013 |
| Priority: | Standard | Application Received: | 10/31/2013 |

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 licensed in Chiropractor 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 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:

The patient is a 42-year-old male who reported an injury on 09/10/2009. The mechanism of injury was noted to be continuous trauma to the left shoulder. The patient is diagnosed with status post left shoulder subacromial decompression and left TFCC pain. A 10/08/2013 visit indicates that the patient has continued complaints of pain to the left shoulder and weakness in his left arm, as well as pain with range of motion. It is noted that with chiropractic treatment the patient has an increased ability to complete his ADLs and has decreased his medications by half. His physical examination findings at his 10/08/2013 visit indicate that his range of motion is 120 degrees flexion, 120 degrees abduction and internal rotation to L3. His motor strength is noted to be 4/5 in extension and abduction. A chiropractic note dated 08/12/2013 indicated that the patient's range of motion was 100 degrees abduction, 100 degrees flexion, and normal in internal rotation. His treatment plan is noted to include therapeutic exercise, postural education/correction, soft tissue and joint mobilization, and other modalities as indicated.

IMR ISSUES, DECISIONS AND RATIONALES

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

Chiropractic therapy two times a week for six weeks for the left shoulder: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG (Shoulder Chapter)

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Manual therapy and manipulation Page(s): 58-59.

Decision rationale: According to the California MTUS Guidelines, manual therapy and manipulation may be recommended for chronic pain caused by musculoskeletal conditions when used as an adjunct to a therapeutic exercise program in order to facilitate progress functionally and return to productive activities. The guidelines further state that the time to produce effect with manipulation is 4 to 6 treatments and with documented evidence of functional gains with previous treatments, manual therapy manipulation may be recommended for up to 8 weeks. The clinical information submitted for review indicates that the patient made objective functional gains with his previous 12 visits of chiropractic care from 08/12/2013 to 09/23/2013. Additionally, documentation shows that the patient is better able to participate in his activities of daily living and has been able to reduce his medications. Due to the documentation indicating that the patient has had decreased pain and increased function with his previous 12 chiropractic visits and the chiropractic care includes active therapies specified as therapeutic exercise, the request for continued chiropractic therapy is supported by evidence-based guidelines. However, as the patient was noted to have previously had approximately 6 weeks of chiropractic care, the request for continued therapy 2 times a week for 6 weeks is not supported by the guidelines as the guidelines specifically state that after 8 weeks of treatment, continued care may be indicated for certain chronic pain patients at 1 treatment every other week until the patient has reached plateau. Therefore, despite the patient's documented evidence of objective functional gains, the request for chiropractic treatments 2 times a week for 6 weeks exceeds the guidelines recommendation of 1 treatment every other week with documentation of functional gains until the patient reaches a plateau. For this reason, the requested service is non-certified.