

Case Number:	CM13-0047440		
Date Assigned:	01/10/2014	Date of Injury:	10/01/1999
Decision Date:	04/07/2014	UR Denial Date:	10/21/2013
Priority:	Standard	Application Received:	11/01/2013

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a 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 female who reported an injury on 10/01/1999. The letter dated 09/10/2013 indicated the patient had returned on 09/09/2013 subsequent to a flare up episode to her right neck, mid back, and shoulder region that was not relieved by independent care. The provider reported since the patient's previous flare and visit to the office in August she had stated good stabilization, flexibility, and reduction in pain and its frequency. 3 days prior to the return to the office, she began experiencing increased achiness, tension, and stiffness over the right neck, upper to mid shoulder blade regions constantly 5/10 to 6/10 with increase pain and difficulty moving her head on driving, reading, or working at the computer for any length of time. The patient reported she had been doing her exercises of strengthening, band, swimming, walking, and use of ice/heat, and over-the-counter ibuprofen prior to the flare and afterwards. Upon examination on 09/09/2013, there was slight tenderness to the right biceps, rotator cuff, and slight to moderate right upper/mid scapula, supraclavicular, cervical region with slight to moderate right supraclavicular, SCM, upper trapezius, and slight right biceps, rotator cuff, latissimus dorsi spasm. The cervical range of motion was restricted 15% on bilateral rotation, 10% on bilateral lateral flexion, 5% in flexion with dull right cervical-scapular pain active/passive flexion, bilateral lateral flexion/rotation. The shoulder range of motion was restricted 10% to 15% in abduction, 5% in internal rotation with slight dull right shoulder-AC joint pain active/passive flexion, abduction, internal rotation. There was slight dull right shoulder pain on Apley's scratch and empty can testing. There was dull right C/T pain on bilateral shoulder depression and relief on cervical distraction testing. There were multiple trigger points noted right upper/mid scapular, supraclavicular, right infraspinatus regions. There was motion palpation fixations-subluxations noted at right C4 to C7, left C1 to C3, T2 to T6, and right shoulder levels. The diagnoses provided were chronic cervical and thoracic strain/sprain,

shoulder tenosynovitis, rotator cuff syndrome, upper extremity/cervical/thoracic segmental dysfunction, myofibrositis, and myospasm. It is noted the treatment consisted of chiropractic manipulation/mobilization with adjunctive ultrasound, G5 massage, manual trigger point, myofascial release, and review of home care, exercise, and proper ergonomics.

IMR ISSUES, DECISIONS AND RATIONALES

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

request for continued Chiropractic treatment 2 visits every 2 weeks for the Shoulder to include CS and TS: Upheld

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

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

Decision rationale: The request for continued chiropractic treatment 2 visits every 2 weeks for the shoulder to include CS and Tinel's sign is non-certified. The California MTUS states that manual therapy and manipulation is recommended for chronic pain if caused by musculoskeletal conditions. The intended goal or effect of manual medicine is to the achievement of positive symptomatic or objective measurable gains and functional improvement that facilitate progression in the patient's therapeutic exercise program and return to productive activities. It is recommended as an option for low back pain a trial of 6 visits over 2 weeks, with evidence of objective functional improvement, total of 18 visits over 6 to 8 weeks. The records provided for review failed to include documentation of objective measurable gains in functional improvement from the previous chiropractic treatments the patient had received. The request for continued chiropractic treatment 2 visits every 2 weeks for the shoulder to include CS and Tinel's sign is not supported. Therefore, the request is not medically necessary.