

Case Number:	CM14-0008683		
Date Assigned:	04/09/2014	Date of Injury:	11/21/2011
Decision Date:	06/30/2014	UR Denial Date:	01/16/2014
Priority:	Standard	Application Received:	01/22/2014

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 Chiropractic 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:

The injured worker is a 47-year-old male who reported an injury on 12/21/2011. The mechanism of injury was not provided for review. The injured worker was conservatively treated with physical therapy, chiropractic care, acupuncture, injections, and medications that failed to resolve the injured worker's symptoms. The injured worker ultimately underwent rotator cuff repair on 10/12/2013. This was followed by postoperative physical therapy and chiropractic care. The injured worker was evaluated on 11/15/2013. It was documented that the injured worker had continued 5/10 pain with decreased range of motion due to the recent rotator cuff repair and 4/5 motor strength in all major muscle groups of the bilateral upper extremities. The injured worker's diagnoses included status post rotator cuff repair with residual pain. The injured worker's treatment recommendations included continued chiropractic care and medications.

IMR ISSUES, DECISIONS AND RATIONALES

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

ADDITIONAL CHIROPRACTIC THERAPY (3) TIMES A WEEK FOR (2) WEEKS FOR THE RIGHT SHOULDER: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

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

Decision rationale: The requested 6 additional chiropractic therapy 3 times a week for 2 weeks for the right shoulder is not medically necessary or appropriate. The clinical documentation submitted for review does indicate that the injured worker has participated in chiropractic care postsurgically. California Medical Treatment Utilization Schedule recommends that continuation of treatment be based on documented functional benefit and symptom relief. The clinical documentation submitted for review does not provide any quantitative objective measures to support functional increases as a result of prior chiropractic treatment. Therefore, additional chiropractic care would not be supported. As such, the requested additional chiropractic therapy 3 times a week for 2 weeks for the right shoulder is not medically necessary or appropriate.