

Case Number:	CM14-0108108		
Date Assigned:	08/01/2014	Date of Injury:	03/07/2009
Decision Date:	10/14/2014	UR Denial Date:	06/26/2014
Priority:	Standard	Application Received:	07/11/2014

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 Board Certified in Orthopedic Surgery 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:

This 67-year-old female laborer sustained an industrial injury on 3/7/09 relative to cumulative trauma. Past medical history was positive for diabetes. The 4/30/14 treating physician initial report cited right shoulder pain at night, reaching overhead, lifting, and going through an arc of motion. Neck pain was also reported. Prior treatment had included extensive physical therapy and multiple injections to the neck and shoulder. Right shoulder exam documented tenderness over the anterior acromial margin and acromioclavicular (AC) joint. Range of motion testing documented flexion 170, external rotation 80 and internal rotation 70 degrees. Speed's and impingement tests were positive. There was pain and weakness with resisted external rotation. Imaging studies were not available. Cervical exam documented diminished range of motion with muscle guarding and sensorimotor intact. The diagnosis was right shoulder pain and dysfunction, AC joint arthrosis, impingement, and rule-out rotator cuff tear. The treatment plan included right shoulder MRI, medications, home exercise and consider right shoulder arthroscopy. The patient last worked in 2009. The 6/11/14 treating physician report cited complaints of constant moderate right shoulder pain radiating to the right upper extremity. The physical exam findings were unchanged from the 4/30/14 report. The treatment plan included continued chiropractic 2-3 times per week for 6 weeks, obtain MRI scan, home range of motion exercise, consider right shoulder arthroscopy, continue medications, and urine toxicology. The 6/26/14 utilization review denied the request for chiropractic treatment as there was no documentation of subjective/objective improvement or reason why the patient was not able to continue with rehabilitation on a home exercise program basis. The request for right shoulder arthroscopy was denied as there was no documentation of MRI studies or conservative treatment, including a corticosteroid injection.

IMR ISSUES, DECISIONS AND RATIONALES

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

Chiropractic Treatment two (2) to three (3) times a week for six (6) weeks to the Right Shoulder: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Manual therapy & manipulation.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Pain outcomes and endpoints, Manual therapy and manipulation Page(s): 9; 58.

Decision rationale: The California MTUS guidelines support chiropractic manipulation for chronic pain if caused by musculoskeletal conditions. The intended goal of manual medicine is the achievement of positive symptomatic or objective measurable gains in functional improvement that facilitate progression in the patient's therapeutic exercise program and return to productive activities. All therapies are to be focused on the goal of functional restoration rather than merely the elimination of pain. Guideline criteria have not been met. There is no clear indication of how much chiropractic treatment has been provided, and what, if any, objective functional benefit has been achieved. There is no change in the physical exam over the prior 2 months. There is no current functional assessment or specific functional deficit to be addressed by chiropractic. There is no indication why a home exercise program would be insufficient. Therefore, this request is not medically necessary.

Right Shoulder Arthroscopy: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 209-211.

Decision rationale: The California MTUS ACOEM guidelines state that surgical consideration may be indicated for patients who have red flag conditions or activity limitations of more than 4 months, failure to increase range of motion and shoulder muscle strength even after exercise programs, and clear clinical and imaging evidence of a lesion that has been shown to benefit, in the short and long-term, from surgical repair. Guideline criteria have not been met. MRI imaging studies have not been provided. There is no imaging evidence of a surgical lesion documented in the available records or by the treating physician. There is no evidence that the patient failed to improve with exercise. There is no specific surgical treatment plan documented. Therefore, this request is not medically necessary.