MAXIMUS Federal Services

Case Number:	CM14-0151149		
Date Assigned:	09/19/2014	Date of Injury:	10/31/2010
Decision Date:	10/20/2014	UR Denial Date:	08/22/2014
Priority:	Standard	Application Received:	09/16/2014

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 Anesthesiology, has a subspecialty in Pain Management 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:

According to the records made available for review, this is a 55-year-old male with a 10/31/10 date of injury and status post right shoulder arthroscopy on 9/15/11. At the time (7/29/14) of request for authorization for Chiropractic treatment, QTY: 6 to 8 sessions and MRI (Magnetic Resonance Imaging), there is documentation of subjective (right shoulder pain with occasional tingling in the right arm) and objective (tenderness to palpation over the right shoulder with improved range of motion, positive Apley's test, positive supraspinatus test, and positive impingement test) findings, imaging findings (MRI of the right shoulder (3/6/12) report revealed post distal clavicular excision procedure with subsequent widened acromioclavicular joint space, moderate effusion, synovitis and mild inflammatory changes in the subacromial/subdeltoid bursa; mild to moderate supraspinatus and infraspinatus tendinopathy; and degenerative appearance of the superior and posterior labrum), current diagnoses (shoulder sprain/strain), and treatment to date (7 chiropractic sessions with improved range of motion, decreased pain, increased ability to perform activities of daily living, and decreased work restrictions). Medical report identifies a request for MRI of the right shoulder. Regarding MRI (Magnetic Resonance Imaging), there is no documentation of a diagnosis/condition (with supportive subjective/objective findings) for which a repeat study is indicated (to diagnose a change in the patient's condition marked by new or altered physical findings).

IMR ISSUES, DECISIONS AND RATIONALES

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

Chiropractic treatment, QTY: 6 to 8 sessions: Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Manual Therapy and Manipulation.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Manual Therapy & manipulation Page(s): 58. Decision based on Non-MTUS Citation Other Medical Treatment Guideline or Medical Evidence: Title 8, California Code of Regulations, section 9792.20

Decision rationale: MTUS Chronic Pain Medical Treatment Guidelines identifies that manual therapy/manipulation is recommended for chronic pain if caused by musculoskeletal conditions, and that the intended goal or effect 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. MTUS additionally supports a total of up to 18 visits over 6-8 weeks. MTUS-Definitions identifies that any treatment intervention should not be continued in the absence of functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications or medical services. Within the medical information available for review, there is documentation of a diagnosis of shoulder sprain/strain. In addition, there is documentation of at least 7 previous chiropractic treatments. Furthermore, given documentation of improved range of motion, decreased pain, increased ability to perform activities of daily living, and decreased work restrictions with previous chiropractic treatments, there is documentation of positive symptomatic or objective measurable gains in functional improvement with previous treatment; and functional benefit or improvement as an increase in activity tolerance as a result of chiropractic therapy provided to date. Therefore, based on guidelines and a review of the evidence, the request for Chiropractic treatment, QTY: 6 to 8 sessions is medically necessary.

MRI (Magnetic Resonance Imaging): Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation MRI Secondary Guideline,Official Disability Guidelines (ODG), Online

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 214. Decision based on Non-MTUS Citation Other Medical Treatment Guidelines: Official Disability Guidelines (ODG) Minnesota Rules, 5221.6100 Parameters for Medical Imaging

Decision rationale: MTUS reference to ACOEM Guidelines identifies documentation of preoperative evaluation of partial thickness or large full-thickness rotator cuff tears, as criteria necessary to support the medical necessity of shoulder MRI. ODG identifies documentation of acute shoulder trauma, suspect rotator cuff tear/impingement; over age 40; normal plain radiographs; subacute shoulder pain, or suspect instability/labral tear, as criteria necessary to support the medical necessity of shoulder MRI. ODG identifies documentation of a diagnosis/condition (with supportive subjective/objective findings) for which a repeat study is

indicated (such as: To diagnose a suspected fracture or suspected dislocation, to monitor a therapy or treatment which is known to result in a change in imaging findings and imaging of these changes are necessary to determine the efficacy of the therapy or treatment (repeat imaging is not appropriate solely to determine the efficacy of physical therapy or chiropractic treatment), to follow up a surgical procedure, to diagnose a change in the patient's condition marked by new or altered physical findings) as criteria necessary to support the medical necessity of a repeat MRI. Within the medical information available for review, there is documentation of a diagnosis of shoulder sprain/strain. In addition, there is documentation of a request for MRI of the right shoulder. Furthermore, there is documentation of a previous right shoulder MRI performed on 3/6/12. However, despite documentation of subjective (right shoulder pain with occasional tingling in the right arm) and objective (tenderness to palpation over the right shoulder with improved range of motion, positive Apley's test, positive supraspinatus test, and positive impingement test) findings, there is no documentation of a diagnosis/condition (with supportive subjective/objective findings) for which a repeat study is indicated (to diagnose a change in the patient's condition marked by new or altered physical findings). Therefore, based on guidelines and a review of the evidence, the request for MRI (Magnetic Resonance Imaging) is not medically necessary.