

<b>Case Number:</b>	CM14-0029508		
<b>Date Assigned:</b>	06/20/2014	<b>Date of Injury:</b>	03/15/2010
<b>Decision Date:</b>	07/17/2014	<b>UR Denial Date:</b>	02/21/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	03/07/2014

### 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 Physical Medicine and Rehabilitation and is licensed to practice in Texas and Oklahoma. 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 38-year-old male who reported an injury on 03/15/2010. The mechanism of injury was not provided for review. Prior conservative treatments included physical therapy, medication. Within the clinical note dated 01/28/2014, it was reported the injured worker complained of left shoulder pain and pain in his upper extremities with numbness. The injured worker reported his last adjustment helped with pain and tingling in the upper extremity. Upon physical examination, the provider indicated palpation of the muscles revealed hypertonicity in the left cervical dorsal, left mid thoracic, left cervical and upper thoracic. The provider indicated the injured worker to have active trigger points in the left trapezius, upper and lower, left levator scapula and left latissimus dorsi muscle. Within the clinical note dated 03/04/2014, the injured worker complained of constant, sharp, burning, shooting and tingling discomfort in the front of the left shoulder. He rated the intensity of discomfort 5/10. The injured worker reported that the discomfort increased with movement. Upon physical examination, the provider noted palpation of the muscles revealed hypertonicity of the left cervical dorsal, left mid thoracic, left cervical, and cervical and upper thoracic. The provider requested for chiropractic manipulation and physiotherapy of the left shoulder. However, a rationale was not provided for review. The Request for Authorization was not provided in the clinical documentation submitted.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**CHIROPRACTIC MANIPULATION:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG; Chiropractic.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Manual Therapy & Manipulation Page(s): 58, 59.

**Decision rationale:** The request for chiropractic manipulation is not medically necessary. The injured worker complained of constant, sharp, burning, shooting, and tingling discomfort in the front of the left shoulder. He rated his pain at 5/10 in severity. He reported discomfort is increased with movement. The California MTUS Guidelines recommend that manual therapy for chronic pain is caused by musculoskeletal conditions. The intended goal or effect of manual therapy is the achievement of positive, symptomatic, or objective measurable gains in functional improvement that facilitate progression in the injured worker's therapeutic exercise program and return to productive activities. The guidelines recommend a trial of 6 visits over 2 weeks, and the evidence of objective functional improvement, a total of 18 visits over 6 to 8 weeks. There is a lack of documentation indicating the injured worker had significant functional improvement with prior therapy. There is a lack of documentation on the physical examination to evaluate for decreased functional ability, decreased range of motion, and decreased strength and flexibility. The amount of chiropractic visits the injured worker previously completed was not provided in the documentation submitted. The request submitted failed to provide the frequency of chiropractic visits. In addition, the request does not specify a treatment site. Therefore, the request for chiropractic manipulation is not medically necessary.

**PHYSIOTHERAPY LEFT SHOULDER:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Postsurgical Treatment Guidelines. Decision based on Non-MTUS Citation ODG; Physiotherapy; Rotator cuff syndrome/impingement syndrome.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Physical Therapy Page(s): 98,99.

**Decision rationale:** The request for physiotherapy of the left shoulder is not medically necessary. The injured worker complained of constant, sharp, burning, shooting, and tingling discomfort in the front of the left shoulder. He rated his pain at 5/10 in severity. He reported discomfort is increased with movement. The California MTUS Guidelines state active therapy is based on the philosophy that therapeutic exercise and/or activity are beneficial for restoring flexibility, strength, endurance, function, range of motion, and can alleviate discomfort. Active therapy requires an internal effort by the individual to complete a specific exercise or task. The guidelines note injured workers are instructed and expected to continue active therapies at home as an extension of their treatment process in order to maintain improvement levels. There is a lack of documentation indicating the injured worker's prior course of physical therapy as well as the efficacy of the prior therapy. The guidelines note for neuralgia and myalgia 8 to 10 visits of physical therapy are recommended. There is a lack of documentation including an adequate and complete physical examination demonstrating the injured worker had decreased functional ability, decreased range of motion, and decreased strength or flexibility. The request submitted

failed to specify the amount or the frequency of therapy. Therefore, the request of physiotherapy of the left show is not medically necessary.