

Case Number:	CM14-0048103		
Date Assigned:	07/02/2014	Date of Injury:	10/27/2001
Decision Date:	10/08/2014	UR Denial Date:	04/01/2014
Priority:	Standard	Application Received:	04/16/2014

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 General Surgery, has a subspecialty in Surgical Critical Care 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 injured worker is a 43 year old female who was injured on October 27, 2001. The mechanism of injury is undisclosed. The diagnosis is listed as displacement of cervical intervertebral disc without myelopathy (722.0). The most recent progress note dated 3/18/14, reveals complaints of frequent constant moderate to severe radiating neck pain to the right side with slight improvement. Physical examination reveals severe to moderate palpable tenderness, slightly improved range of motion flexion 15/45, right rotation 55/90, left rotation 60/90, +CCT, +CDT, +FCT, and +shoulder dist, right shoulder severe palpable tenderness, slightly improved range of motion abduction 100/170, flexion 90/170, internal rotation 35/60, external rotation 10/30, adduction 15/30, Appley's scratch, +apprehension. Prior treatment includes thirteen previous chiropractic treatments which provide excellent, but transient relief. A prior utilization review determination dated 4/1/14 resulted in denial of MRI scan of cervical spine, MRI scan of right shoulder, additional chiropractic care and physiotherapy three times a week for two weeks, then continue at two times a week for one week, total eight visits.

IMR ISSUES, DECISIONS AND RATIONALES

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

MRI scan of Cervical Spine: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Neck & upper back Complaints Page(s): 177-179. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Neck & Upper Back, MRI

Decision rationale: The claimant appears to have chronic neck pain following a work injury in 2001. Although there is range of motion (ROM) deficiencies on office note of 3/18/14, there are no neurologic deficits in motor, sensory or deep tendon reflexes reported such that repeat MRI of the cervical spine would be medically necessary. Medical necessity has not been established.

MRI scan of Right Shoulder: 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): 207-209. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder, MRI

Decision rationale: This is a claimant who was initially injured in 2001. There is a recent physical exam of 3/18/14 that documents Apley's and impingement testing positive for the right shoulder. There is inadequate documentation as to what conservative measures have been expended and their results if any. While there is positive orthopedic test such as Apley's scratch test and Impingement signs, generally conservative measures should be expended before consideration of imaging or special studies.

Additional Chiropractic care and Physiotherapy 3 times a week for 2 weeks, then continue at 2 times a week for 1 week , total 8 visits: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) ,Chiropractic Guidelines; ODG Shoulder Chapter

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines MANUAL THERAPY & MANIPULATIONS Page(s): 58-60. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder, Physical Therapy

Decision rationale: The medical documentation does not support the protracted chiropractic and physical therapy as requested. The claimant was initially injured in 2001. Since that time he has been afforded 13 sessions which provided only transient relief of symptoms per the office note of 3/28/14. Therefore repeat chiropractic care requested is not medically necessary as it provided no long term relief of symptoms. With regards the extra physical therapy, the claimant has been afforded previous multiple sessions of physical therapy such that he should be able to resume a self-directed Home exercise program. Therefore the 8 additional sessions remains not medically necessary.