

Case Number:	CM14-0049012		
Date Assigned:	06/25/2014	Date of Injury:	08/31/2012
Decision Date:	07/29/2014	UR Denial Date:	03/09/2014
Priority:	Standard	Application Received:	03/26/2014

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 patient is a 59 year old male who was injured on 08/31/2012. The mechanism of injury is unknown. Prior treatment history has included physical therapy. The patient underwent right shoulder A/S, debridement, SAD, RTC repair on 09/12/2013. Progress report dated 02/26/2014 reports the patient complained of right shoulder pain rated as a 3-4/10. He also complains of low back pain rated as 8/10 radiating to the right leg. Objective findings on exam revealed normal range of motion of the right shoulder. There is tenderness to palpation over the AC joint. There is tenderness at the anterior acromiale margin. Positive Speed's test and positive impingement test. He has discomfort on drop arm testing. There is tenderness to palpation to the lumbar paraspinal muscle with full range of motion of the lumbar spine. Heel to toe walk is normal. Diagnoses are right shoulder residual after prior arthroscopic surgery with repair of the rotator cuff; residual downsloping anterolateral acromiale spur with residual impingement, AC joint arthrosis, and adhesive capsulitis, and lumbar sprain/strain. The patient has been recommended to complete physical therapy and recommended 2 to 3 sessions of chiropractic therapy for 6 weeks. The patient is recommended to undergo physical therapy twice a week for 6 weeks for the low back. Prior utilization review dated 03/09/2014 states the request for 18 sessions of chiropractic treatment was not authorized as the patient had improvement with prior therapy and remaining deficits should be able to address with a home exercise program. The request exceeds the guideline recommendations.

IMR ISSUES, DECISIONS AND RATIONALES

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

18 Chiropractic visits for the right shoulder: Upheld

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): 58-60. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Shoulder / Manipulation.

Decision rationale: Review of records document this is a patient age 59 who suffered an industrial accident on 08/31/2012. The records also document this patient has had surgical intervention to his right shoulder. The patient underwent right shoulder A/S, debridement, SAD, RTC repair on 09/12/201. The records also document this patient was authorized 12 Physical Therapy treatments to his shoulder and lower back. The records do not indicate the number of these PT visits completed nor do they document what specific improvements in functional capacity was achieved. The CA MTUS guidelines allow for manual therapies for chronic pain if caused by musculoskeletal conditions. Manual Therapy is widely used in the treatment of musculoskeletal pain. The intended goal or effect of Manual Medicine is the achievement of positive symptomatic or objective measurable gains in functional improvement that facilitate the progression in the patient's therapeutic exercise program and return to productive activities. Manipulation is manual therapy that moves a joint beyond the physiologic range-of-motion but not beyond the anatomic range-of-motion. The records do not document if the patient is active in an HEP as recommended by the guidelines nor do the records specific what specific improvement in functional capacity would be expected by additional Chiropractic x18 visit to the shoulder. The Chiropractic ODG guidelines for shoulder state the following: There is limited evidence to specifically support the utilization of manipulative procedures of the shoulder, but this procedure is routinely applied by chiropractic providers whose scope allows it, and the success of chiropractic manipulation for this may be highly dependent on the patient's previous successful experience with a chiropractor. In general, it would not be advisable to use this modality beyond 2-3 visits if signs of objective progress towards functional restoration are not demonstrated. A recent clinical trial concluded that manipulative therapy for the shoulder girdle in addition to usual medical care accelerates recovery of shoulder symptoms. (Bergman, 2004) (Michener, 2004) A recent meta-analysis concluded that there is limited evidence which supports the efficacy of manual therapy in patients with a shoulder impingement syndrome. (Verhagen-Cochrane, 2004) There is fair evidence for the treatment of a variety of common rotator cuff disorders, shoulder disorders, adhesive capsulitis, and soft tissue disorders using manual and manipulative therapy (MMT) to the shoulder, shoulder girdle, and/or the full kinetic chain combined with or without exercise and/or multimodal therapy. There is limited and insufficient evidence for MMT treatment of minor neurogenic shoulder pain and shoulder osteoarthritis, respectively. (Brantingham, 2011) According to this systematic review, manipulation performed about the same as steroid injections for frozen shoulder. (Tashjian, 2012) The latest UK Health Technology Assessment on management of frozen shoulder concludes that based on the best available evidence there may be benefit from stretching and from high-grade mobilization technique. (Maund, 2012) See also Physical therapy. ODG Chiropractic Guidelines- Sprains and strains of shoulder and upper arm: Allow for fading of treatment frequency (from up to 3 visits per week to 1 or less), plus active self-directed home therapy Per the ODG guidelines, with a

date of injury of 08/31/2012, this patient is far beyond the initial 3 visits within the first week where maximum improvement would be expected and should have been transitioned to an HEP. Therefore treatment request does not meet the ODG guidelines for Chiropractic treatment to the shoulder. Per the CA MTUS guidelines, again this patient is far beyond the initial 6 visit within the first 2 weeks. Also per the guidelines, as stated above, there is no documentation addressing improvement in functional capacity with prior treatment or documentation as to what gains would be expected with continued treatment. Therefore this request for Chiropractic x 18 treatments does not meet the CA MTUS guidelines. Decision for Chiropractic treatments x18 to the right shoulder is not medically necessary.