

Case Number:	CM14-0065003		
Date Assigned:	07/11/2014	Date of Injury:	03/01/2013
Decision Date:	08/08/2014	UR Denial Date:	04/25/2014
Priority:	Standard	Application Received:	05/08/2014

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 a licensed Chiropractor 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 31-year-old male who reported an injury on 03/01/2013. He was reportedly installing a solid wood and metal exterior door when the door shifted and slammed his left shoulder. On 05/02/2014, the injured worker presented with low back pain and left shoulder pain. Upon examination, the injured worker had a positive O'Brien's test and tenderness over the biceps tendon groove. Prior therapy included medications. The diagnosis was superior labral pathology, symptomatic. The provider recommended chiropractic therapy for the left shoulder; the provider's rationale was not provided. The Request for Authorization form was not included in the medical documents for review.

IMR ISSUES, DECISIONS AND RATIONALES

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

Chiropractic therapy for left shoulder 3x6, Qty:18 sessions: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 203, Chronic Pain Treatment Guidelines Manual therapy and manipulation. Decision based on Non-MTUS Citation ODG Shoulder (Official Disability Guidelines).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine, page(s) 58 Page(s): 58.

Decision rationale: The request for chiropractic therapy for the left shoulder 3 times a week for 6 weeks with a quantity of 18 sessions is non-certified. The California MTUS Guidelines state that chiropractic care for chronic pain if caused by musculoskeletal conditions is recommended. 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 injured worker's therapeutic exercise program and return to productive activities. The guidelines recommend a trial of 6 visits over 2 weeks, and with evidence of functional improvement, a total of up to 18 visits over 6 to 8 weeks. The provider's request for chiropractic therapy 3 times a week for 6 weeks with a quantity of 18 exceed the guidelines recommendations. As such, the request is not medically necessary.