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| Case Number: | CM14-0084607 | | |
| Date Assigned: | 07/21/2014 | Date of Injury: | 01/10/2012 |
| Decision Date: | 08/27/2014 | UR Denial Date: | 05/05/2014 |
| Priority: | Standard | Application Received: | 06/06/2014 |

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 Ohio 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 45-year-old male who reported an injury on 01/10/2012, secondary to an unspecified mechanism of injury. The injured worker was evaluated on 02/21/2014 for reports of left shoulder pain. The exam noted tenderness over the biceps tendon, rotator cuff, and subacromial region of the left shoulder. The range of motion was noted to be at 165 degrees for flexion, 20 degrees for extension, 150 degrees for abduction, 20 degrees for adduction, 70 degrees for internal rotation, and 75 degrees for external rotation. The cervical spine examination noted the range of motion to be at 35 degrees for flexion, 40 degrees for extension, 35 degrees for bilateral bending, and 70 degrees for bilateral rotation. The diagnoses included left shoulder impingement syndrome, and status post arthroscopy of the left shoulder. The treatment plan included continued medication therapy. The Request for Authorization and rationale for requests were not include in the documentation.

IMR ISSUES, DECISIONS AND RATIONALES

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

8 Sessions of Chiro Therapy Neck Left Shoulder: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 173,Chronic Pain Treatment Guidelines Chronic Pain Treatment Guides; Chiropractic Treatment; Manual therapy & manipulation Page(s): 173.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Manual Manipulation and Therapy, page(s) 58-60 Page(s): 58-60.

Decision rationale: The request for 8 sessions of chiropractic therapy for the neck and left shoulder is non-certified. The California MTUS guidelines may recommend chiropractic care for chronic pain is caused by musculoskeletal conditions. The guidelines also recommend a trial of 6 visits over 3 weeks with evidence of objective functional improvement, and a total of up to 18 visits over 6 to 8 weeks, if functional improvement is gained. There is a significant lack of clinical evidence in the documentation provided of evaluation of prior chiropractic treatments. The request for 8 chiropractic sessions exceeds the recommended number of sessions during the trial of phase of therapy. Therefore, due to the significant lack of clinical evidence of the efficacy of prior trials of chiropractic care and the number of visits being requested exceeding the recommended number of visits during the trial phase per the guidelines, the request for 8 sessions of chiropractic therapy for the neck and left shoulder is not medically necessary.

MR Arthrogram of left shoulder: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 177-179, Chronic Pain Treatment Guidelines Chronic Pain Treatment; Special Studies and Diagnostic and Treatment Considerations Page(s): 177-179.

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, MR arthrogram.

Decision rationale: The request for MR Arthrogram of left shoulder is certified. The California MTUS/ACOEM Guidelines state MRI and MR arthrography have familiar diagnostic and therapeutic impact. The guidelines further state MRI is the preferred as it has better soft tissue accuracy. The Official Disability Guidelines may recommend MR arthrography to diagnose labral tears. Although the injured worker has a suspected labral tear, there is a significant lack of clinical evidence of failure of conservative therapies such as physical therapy. Therefore, due to the lack of evidence of failure of conservative therapies, the request is not medically necessary.