

Case Number:	CM14-0085599		
Date Assigned:	07/23/2014	Date of Injury:	09/06/2013
Decision Date:	08/27/2014	UR Denial Date:	05/29/2014
Priority:	Standard	Application Received:	06/09/2014

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 Chiropractic, has a subspecialty in Acupuncture, 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 injured worker is a 49 year old female who reported left shoulder, left hand, and right knee pain from an injury sustained on 9/6/13 due to a fall. An MRI of the right knee revealed medial meniscus tear, partial tear of the posterior cruciate ligament, and mild tendinitis of the quadriceps ligament. An MRI of the left shoulder reveals mild impingement syndrome, tendinosis, and edema of the rotator cuff with partial tear beneath the acromion. An MRI of the lumbar spine revealed disc desiccation at L4-5 with degenerative changes and L4-5 disc protrusion. The patient is diagnosed with sprain of hand, sprain of lateral collateral ligament, medial meniscus tear, lumbago, joint pain-leg, lumbosacral neuritis, lumbar disc displacement, and sprain of rotator cuff. The patient has been treated with medication, acupuncture, physical therapy, and chiropractic. Per chiropractic progress notes dated 1/29/14, the patient complains of pain in the right knee rated at 9/10 with radiating pain up to the thigh and left shoulder pain rated at 7/10. Per medical notes dated 4/10/14, the patient complains of pain to the right shoulder that radiates down to the left hand with constant hand movements (7/10). The patient also has pain to the right knee with prolonged walking and standing, rated 7/10. Per medical notes dated 6/6/14, the patient complains of pain to right knee with repetitive walking and standing for long periods of time. Pain is rated at 7/10 and left shoulder pain is rated at 7/10. Examination revealed tenderness to palpation of the thoracic and lumbar paraspinal as well as tenderness to the left shoulder. The patient hasn't had any long term symptomatic or functional relief with chiropractic care. The patient continues to have pain and flare-ups. Medical reports reveal little evidence of significant changes or improvement in findings, revealing a patient who has not achieved significant objective functional improvement to warrant additional treatment.

IMR ISSUES, DECISIONS AND RATIONALES

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

Outpatient Chiropractic Manipulation three times four (3x4) weeks for the Right Knee, Back (thoracic and lumbar) and Left Shoulder: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines.

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

Decision rationale: The MTUS Chronic Pain Medical Treatment Guidelines state that manual therapy is recommended 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 objectively measurable gains in functional improvement that facilitate progression in the patient's therapeutic exercise program and return to productive activities. It is recommended as an option for the low back with a trial of 6 visits over 2 weeks; with evidence of objective functional improvement, a total of up to 18 visits over 6-8 weeks may be recommended, and elective/maintenance care is not medically necessary. For reoccurrences/flare-ups, the treating physician would need to re-evaluate treatment success. If return to work had been achieved, then 1-2 visits every 4-6 months would be recommended. The patient has had prior chiropractic treatments with symptomatic relief; however, clinical notes fail to document any functional improvement with prior care. Medical reports reveal little evidence of significant changes or improvement in findings, revealing a patient who has not achieved significant objective functional improvement to warrant additional treatment. Per guidelines, functional improvement means either a clinically significant improvement in activities of daily living or a reduction in work restrictions as measured during the history and physical exam. Per review of evidence and guidelines, 12 Chiropractic visits are not medically necessary.