

Case Number:	CM13-0042876		
Date Assigned:	07/16/2014	Date of Injury:	07/21/2006
Decision Date:	01/27/2015	UR Denial Date:	10/04/2013
Priority:	Standard	Application Received:	10/21/2013

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 Orthopedic Surgery, has a subspecialty in Adult Reconstruction Surgery and is licensed to practice in Pennsylvania. 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 37-year-old female who reported an injury on 07/21/2006. The mechanism of injury was not provided. On 09/16/2013, the injured worker presented with ongoing pain to the neck, upper back, and mid back. She also noted right shoulder pain. Physical examination revealed tenderness and muscle guarding in the upper trapezius, rhomboid, and lumbar paravertebral muscles. Official MRI of the right shoulder dated 12/28/2012 revealed mild distal infraspinatus tendinopathy, type 1 acromion with trace fluid within the subacromial/subdeltoid bursa, and mild degenerative changes in the acromioclavicular joint with small joint effusion. The treatment included chiropractic care and medications. The provider recommended a right shoulder arthroscopy, SAD, and evaluation for possible labral tear and continued chiropractic 1x4 for the cervical, thoracic, and lumbar spine. There was no rationale provided. The Request for Authorization form was dated 09/16/2013.

IMR ISSUES, DECISIONS AND RATIONALES

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

Right shoulder arthroscopy, SAD and evaluation for possible labral tear: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines-Treatment for Workman's Compensation, shoulder procedure last updated 06/12/2013 Official Disability Guidelines- indications for surgery-Acromioplasty

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 210-212. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder, Surgery for impingement syndrome.

Decision rationale: The request for right shoulder arthroscopy, and evaluation for possible labral tear is not medically necessary. The Official Disability Guidelines state indications for surgery include failure to respond to 3 to 6 months of conservative treatment, clinical findings of pain with active motion, and pain at night with objective clinical findings of weak or absence abduction, demonstrated atrophy or tenderness over the rotator cuff or anterior acromial area, and a positive impingement sign, with temporary relief of pain with an anesthetic injection. There should also be imaging findings that reveal positive evidence of impingement. The clinical documentation submitted for review failed to show that the patient had failed initially recommended conservative care and treatment. There are no significant deficits noted to the right shoulder. There is no positive provocative testing congruent with impingement. Additionally, there were no imaging studies submitted for review. As such, medical necessity has not been established.

Continued chiropractic 1x4 cervical, thoracic and lumbar spine: 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 Physical Medicine Page(s): 58.

Decision rationale: The request for continued chiropractic 1x4 cervical, thoracic and lumbar spine is not medically necessary. 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 and facilitate progress in the patient's therapeutic exercise program and return to productive activities. The guidelines recommend a trial of 6 visits over 2 weeks and with evidence of objective functional improvement, a total of up to 18 visits over 6 to 8 weeks is recommended. There is lack of documentation indicating that the injured worker had significant objective functional improvement with the prior therapy. Additionally, the amount of prior therapy sessions that the injured worker participated in was not provided. As such, medical necessity has not been established.