

Case Number:	CM14-0008032		
Date Assigned:	02/12/2014	Date of Injury:	05/29/2012
Decision Date:	03/13/2015	UR Denial Date:	01/14/2014
Priority:	Standard	Application Received:	01/22/2014

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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:
 State(s) of Licensure: Virginia
 Certification(s)/Specialty: Chiropractor

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 28-year-old male who reported an injury on 05/29/2012. The mechanism of injury was not submitted for review. The injured worker has diagnoses of traumatic right shoulder impingement syndrome and labral tear, status post right shoulder arthroscopic examination and surgery with repair of the labrum, musculoligamentous sprain/strain of the cervical spine, right shoulder arthroscopic surgery with global pain of the right shoulder and upper extremity, and brachial plexus injury. Past medical treatment consists of surgery, physical therapy, injections, and medication therapy. Medications include Norco, gabapentin, omeprazole, naproxen, and Fexmid. An MRI of the right upper extremity obtained on 10/01/2013, revealed interval subacromial decompression and smooth mild attenuation of the supraspinatus tendon adjacent to the foot print. There was no high grade full thickness tear of the cuff noted, labral truncation superiorly, possibly postsurgical change. On 11/11/2013, the injured worker complained of right shoulder pain. He described it as constant, sharp, throbbing. The injured worker also complained of instability of the right shoulder, which he rated at 8/10, 10 being the worst. Physical examination of the right shoulder revealed no evidence of dislocation or fracture. Inspection revealed the shoulders to be asymmetrical, but at the same level. There was atrophy over the right shoulder girdle. There was swelling of the right hand, dorsal aspect. There was no prominence of the right acromioclavicular joint. There was no evidence of rupture of the right biceps, nor was there tenderness to palpation of the anterior aspect of the right shoulder and greater tuberosity, suprascapular muscles, and acromion. There was no tenderness noted on palpation of the bicipital groove. There was no winging of the

scapulae. Range of motion revealed a forward flexion of 70 degrees, abduction of 60 degrees, adduction of 30 degrees, extension of 20 degrees, internal rotation of 40 degrees, and external rotation of 40 degrees. Tinel's sign in the elbow, Tinel's sign of the wrist, and Phalen's test of the wrist were negative bilaterally. The medical treatment plan is for the injured worker to have noninvasive surgery to the right shoulder and the use of a spinal stimulator at this time. The provider is recommending manipulation of the right shoulder under anesthesia, as well as the use of a CPM machine for 6 to 8 weeks, with progress. The Request for Authorization form was not submitted for review.

IMR ISSUES, DECISIONS AND RATIONALES

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

Chiropractic 2xwk X 6wks Right Shoulder/Cervical Spine/Upper Thoracic: Upheld

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

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

Decision rationale: The request for chiropractic, 2 times a week for 6 weeks, right shoulder/cervical spine/upper thoracic spine, is not medically necessary. The California MTUS Guidelines state that manual therapy and manipulation are recommended for chronic pain, if caused by musculoskeletal conditions. For the cervical spine and shoulder, therapy is recommended initially in a therapeutic trial of 6 sessions and, with objective functional improvement, a total of up to 18 visits over 6 to 8 weeks may be appropriate. The treatment for flare-up requires the need for re-evaluation of prior treatment success. Treatment is not recommended for the ankle and foot, carpal tunnel syndrome, the forearm, wrist, and hand, or knee. If chiropractic treatment is going to be effective, there should be some outward sign of subjective or objective improvement within the first 6 sessions. Treatment beyond 4 to 6 visits should be documented, with objective improvement in function. The maximum duration is 8 weeks, and at 8 weeks the patient should be re-evaluated. Care beyond 8 weeks may be indicated for certain chronic pain patients in whom manipulation is helpful in improving function, decreasing pain and improving quality of life. It was indicated in the submitted documentation that the injured worker had pain to the neck and to the right shoulder. Physical examination revealed no gross deformity or surgical scars to the cervical spine. There was no evidence of dislocation or fracture to the right shoulder. It was also indicated in the submitted documentation that the injured worker had undergone prior chiropractic therapy. However, it did not indicate or specify how many sessions the injured worker has completed to date, nor was there mention of efficacy. Additionally, the request as submitted is for a total of 12 weeks, exceeding the recommended guideline for an initial 6 sessions. There were no significant factors provided to justify the use outside of current guidelines. As such, the request is not medically necessary.