

Case Number:	CM14-0210190		
Date Assigned:	12/23/2014	Date of Injury:	12/23/2012
Decision Date:	12/24/2015	UR Denial Date:	11/18/2014
Priority:	Standard	Application Received:	12/15/2014

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: California

Certification(s)/Specialty: Emergency Medicine

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 62 year old female who sustained an industrial injury on 12-23-2012. A review of medical records indicates the injured worker is being treated for right shoulder derangement and right lateral neck pain. Medical records dated 10-7-2014 noted right shoulder and right lateral neck pain. Physical examination noted limited range of motion and pain with palpation to the right shoulder. Treatment has included conservative therapy. Utilization review form noncertified chiropractic therapy 2x6 weeks' cervical right shoulder and referral for medication management.

IMR ISSUES, DECISIONS AND RATIONALES

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

Chiropractic treatment 2 times a week for 6 weeks, cervical, right shoulder: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Manual therapy & manipulation.

Decision rationale: The requested Chiropractic treatment 2 times a week for 6 weeks, cervical, right shoulder, is not medically necessary. CA MTUS Chronic Pain Treatment Guidelines, Manual Therapy and Manipulation, Pages 58-59, recommend continued chiropractic therapy with documented objective evidence of derived functional benefit. The injured worker has right shoulder and right lateral neck pain. Physical examination noted limited range of motion and pain with palpation to the right shoulder. The treating physician has not documented objective evidence of derived functional benefit from completed chiropractic sessions, such as improvements in activities of daily living, reduced work restrictions or reduced medical treatment dependence. The criteria noted above not having been met, Chiropractic treatment 2 times a week for 6 weeks, cervical, right shoulder is not medically necessary.

Referral for medication management: Overturned

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ACOEM, Second Edition, 2004, page 112, 127.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Introduction.

Decision rationale: The requested Referral for medication management is medically necessary. California Medical Treatment Utilization Schedule (MTUS), 2009, Chronic pain, page 1, Part 1: Introduction, states "If the complaint persists, the physician needs to reconsider the diagnosis and decide whether a specialist evaluation is necessary." The injured worker has right shoulder and right lateral neck pain. Physical examination noted limited range of motion and pain with palpation to the right shoulder. As the requesting provider is a chiropractor, the medical necessity has been established for a referral for medication management. The criteria noted above having been met, Referral for medication management is medically necessary.