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| Case Number: | CM15-0003310 | | |
| Date Assigned: | 01/14/2015 | Date of Injury: | 10/02/2014 |
| Decision Date: | 03/10/2015 | UR Denial Date: | 12/17/2014 |
| Priority: | Standard | Application Received: | 01/07/2015 |

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: Chiropractic

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 was a 56 year old male, who sustained an industrial injury on October 2, 2014. The injury occurred when two gentlemen were walking towards the exit with merchandise, as the injured worker walked towards the exit, tripped or slipped and fell. The injured workers chief complaints were right shoulder pain, sharp, constant pain radiating down the right arm to the wrist with limited range of motion. The lower back had sharp burning pain. Also, the injured worker has intermittent pain in the left and right knee. The injured worker was diagnosed with rule out right shoulder rotator cuff tear with impending adhesive capsulitis, cervical strain, thoracolumbar strain and bilateral knee contusions. The injured worker's treatment consisted of pain medication, muscle relaxants, anti-inflammatory medications, chiropractic treatments for the neck and back, massage therapy, TENS unit and heat. The primary treating physician requested chiropractic treatments 1 time a week for 4 weeks including 1 re-evaluation for the right shoulder, left knee, cervical and lumbar spine to assist with pain management. On December 17, 2014, the UR denied authorization for chiropractic treatments 1 time a week for 4 weeks including 1 reevaluation for the right shoulder, left knee, cervical and lumbar spine. The denial was based on the MTUS guidelines for Chronic Pain; regarding manual therapy and manipulation.

IMR ISSUES, DECISIONS AND RATIONALES

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

Chiropractic Treatment Once A Week for 4 Weeks Including 1 Re-Evaluation for Right Shoulder, Left Knee, Cervical and Lumbar Spine: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Manual Therapy and Manipulations.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Neck, Low Back, Knee and Shoulder Chapters Page(s): Manipulation Sections. Decision based on Non-MTUS Citation Neck, Low back, Knee and Shoulder Chapters MTUS Definitions

Decision rationale: In this case the patient has suffered injuries to multiple body regions. Per the records provided, he has received prior chiropractic care for his neck and low back but not to his shoulder and knees. The MTUS Chronic Pain Medical Treatment Guidelines and The ODG Neck, Shoulder and Low Back Chapters for Recurrences/flare-ups states : "Need to re-evaluate treatment success, if RTW achieved then 1-2 visits every 4-6 months when there is evidence of significant functional limitations on exam that are likely to respond to repeat chiropractic care." The same guidelines do not recommend manipulation for the knee. The MTUS-Definitions page 1 defines functional improvement as a "clinically significant improvement in activities of daily living or a reduction in work restrictions as measured during the history and physical exam, performed and documented as part of the evaluation and management visit billed under the Official Medical Fee Schedule (OMFS) pursuant to Sections 9789.10-9789.11; and a reduction in the dependency on continued medical treatment." The PTP describes some Improvements with treatment but no objective measurements are listed. The records provided by the primary treating physician do not show objective functional improvements with ongoing chiropractic treatments rendered. The past chiropractic care records are not present in the records provided. I find that the 4 chiropractic sessions requested to the neck, right shoulder, left knee and low back with one re-evaluation to not be medically necessary and appropriate.