

Case Number:	CM15-0104938		
Date Assigned:	06/09/2015	Date of Injury:	08/08/2014
Decision Date:	07/17/2015	UR Denial Date:	05/05/2015
Priority:	Standard	Application Received:	06/01/2015

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: North Carolina
 Certification(s)/Specialty: Family Practice

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 55 year old male, who sustained an industrial injury on 8/8/14. The injured worker has complaints of right shoulder pain. The documentation noted that the injured worker has complaints of anxiety, sleeplessness, mood changes; feeling of discrimination and depression, and left shoulder continues to develop compensatory pain. The documentation noted that the injured worker has tenderness on palpation with limited, painful range of motion and positive orthopedic evaluation to right shoulder. The diagnoses have included cervicgia; sprains and strains of unspecified site of shoulder and upper arm and calcifying tendinitis of shoulder. Treatment to date has included right shoulder X-ray on 1/7/15 showed no evidence of fracture or dislocation; Nabumetone; Pantoprazole and Cyclobenzaprine cream; hot pack; cold packs; acupuncture; shockwave therapy; massage; traction; ultrasound; exercise; injections; and transcutaneous electrical nerve stimulation unit. The request was for chiropractic manipulation and therapy 1-2 times a week for 6 weeks for the right shoulder and referral to occupational medicine for follow up.

IMR ISSUES, DECISIONS AND RATIONALES

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

Chiropractic manipulation and therapy 1-2 times a week for 6 weeks for the right shoulder: 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 Manual Manipulation Page(s): 58-59.

Decision rationale: The California chronic pain medical guidelines section on manual manipulation states: 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 objective measurable gains in functional improvement that facilitate progression in the patient's therapeutic exercise program and return to productive activities. Manipulation is manual therapy that moves a joint beyond the physiologic range-of-motion but not beyond the anatomic range-of-motion. Low back: Recommended as an option. Therapeutic care: Trial of 6 visits over 2 weeks, with evidence of objective functional improvement, total of up to 18 visits over 6-8 weeks. Elective/maintenance care: Not medically necessary. Recurrences/flare-ups: Need to reevaluate treatment success, if RTW achieved then 1-2 visits every 4-6 months. Ankle & Foot: Not recommended. Carpal tunnel syndrome: Not recommended. Forearm, Wrist, & Hand: Not recommended. Knee: Not recommended. Treatment Parameters from state guidelines: a. Time to produce effect: 4 to 6 treatments Manual manipulation is recommended form of treatment for chronic pain. However, the requested amount of therapy sessions is in excess of the recommendations per the California MTUS. The California MTUS states there should be not more than 6 visits over 2 weeks and documented evidence of functional improvement before continuation of therapy. The request is for greater than 6 sessions. The provided clinical documentation for review does not provide objective reasons that the patient would require more than the recommended amount of sessions to treat the shoulder pain. This does not meet criteria guidelines and thus is not medically necessary.

Referral to occupational medicine for follow up: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Treatment in Workers Compensation (TWC), Pain Procedure Summary, Online Version, last updated 04/06/2015, Evaluation and Management (E&M).

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Medical Reevaluation.

Decision rationale: The California MTUS and the ACOEM do not specifically address the requested service. The ODG states that follow up evaluation is based on medical necessity as dictated by the patient's ongoing complaints/symptoms and response to prescribed therapy. In this case there is no reference to the specialist requested previous treatments, so response cannot be gauged. Therefore, the request is not medically necessary.