

Case Number:	CM15-0202181		
Date Assigned:	10/19/2015	Date of Injury:	02/20/2014
Decision Date:	11/30/2015	UR Denial Date:	10/08/2015
Priority:	Standard	Application Received:	10/15/2015

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 46 year old female, who sustained an industrial injury on February 20, 2014, incurring right shoulder, right knee, and bilateral arm injuries. She was diagnosed with a right shoulder impingement syndrome, right knee meniscus tear, chondromalacia of the right knee and leg sprain. She underwent a right knee arthroscopy in February, 2015. Treatment included anti-inflammatory drugs, pain medications, physiotherapy, chiropractic sessions, acupuncture, and activity restrictions. Currently, the injured worker complained of increased pain and discomfort in the right shoulder. There was increased pain with abduction and rotation of the shoulder. Magnetic Resonance Imaging of the shoulder revealed degenerative changes, bursitis, tendinitis and partial tear of the tendons and superior labral tear. She was diagnosed with right shoulder impingement syndrome and partial tear rotator cuff. The treatment plan that was requested for authorization included a Corticosteroid injection to the right shoulder and six Chiropractic therapy sessions twice weekly to the right shoulder. On October 8, 2015, requests for steroid injection and chiropractic sessions therapy was denied by utilization review.

IMR ISSUES, DECISIONS AND RATIONALES

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

Corticosteroid injection right shoulder with Ultrasound guidance for the right shoulder
QTY 1: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines.

MAXIMUS guideline: Decision based on MTUS Shoulder Complaints 2004, Section(s): Initial Care.

Decision rationale: The ACOEM chapter on shoulder complaints states: Invasive techniques have limited proven value. If pain with elevation significantly limits activities, a subacromial injection of local anesthetic and a corticosteroid preparation may be indicated after conservative therapy (i.e., strengthening exercises and nonsteroidal antiinflammatory drugs) for two to three weeks. The evidence supporting such an approach is not overwhelming. The total number of injections should be limited to three per episode, allowing for assessment of benefit between injections. There is no evidence in the medical records that pain with elevation is significantly limiting activities. There is also no physical exam findings of unusual anatomy that would require ultrasound or fluoroscopic guidance for this routine injection. Therefore the request is not medically necessary.

Chiropractic/Physiotherapy/Manipulation therapy twice weekly, right shoulder QTY 6:
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): Physical Medicine.

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. Previous sessions have not produced documented objective improvements in pain and function. This does not meet criteria guidelines without documentation of objective gains in function and pain and thus is not medically necessary.