

Case Number:	CM15-0032790		
Date Assigned:	02/26/2015	Date of Injury:	02/04/2014
Decision Date:	04/09/2015	UR Denial Date:	02/04/2015
Priority:	Standard	Application Received:	02/23/2015

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: Chiropractor, Oriental 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 30-year-old male who sustained an industrial injury on 02/04/2014. Current diagnoses include lumbar strain and right shoulder surgery. Previous treatments included medication management, right shoulder surgery on 09/19/2014, and physical therapy. Report dated 01/22/2015 noted that the injured worker presented with complaints that included right shoulder pain and low back pain. Physical examination was positive for abnormal findings. Utilization review performed on 02/04/2015 non-certified a prescription for chiropractic 2 times per week for 6 weeks to the lumbar spine and right shoulder, based on the clinical information submitted does not support medical necessity. The reviewer referenced the California MTUS in making this decision.

IMR ISSUES, DECISIONS AND RATIONALES

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

Chiropractic 2 times a week for 6 weeks, Lumbar Spine, Right Shoulder: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Manual therapy and manipulation Page(s): 58-60.

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

Decision rationale: Patient has not had prior chiropractic treatments. Provider requested initial trial of 12 chiropractic treatment for low back and shoulder. Per guidelines, 4-6 treatments are supported for initial course of Chiropractic with evidence of functional improvement prior to consideration of additional care. Requested visits exceed the quantity of initial Chiropractic visits supported by the cited guidelines. Additional visits may be rendered if the patient has documented objective functional improvement. MTUS- Definition 9792.20 (f) Functional improvement means either a clinically significant improvement in activities of daily living or a reduction in work restrictions as measured during the history and physical exam. MTUS guidelines do not recommend chiropractic for shoulder pain. Per guidelines and review of evidence, 12 Chiropractic visits are not medically necessary.