

Case Number:	CM15-0034461		
Date Assigned:	03/02/2015	Date of Injury:	01/11/2013
Decision Date:	04/08/2015	UR Denial Date:	01/28/2015
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 29 year old male, who sustained an industrial injury on 01/11/2013. He has reported subsequent back and shoulder pain and was diagnosed with sprain/strain of the thoracic spine and sprain/strain with underlying rotator cuff tendinitis and bicipital tenosynovitis. Treatment to date has included oral pain medication, inferential unit, physiotherapy, chiropractic treatment and acupuncture treatment. In a progress note dated 10/31/2014, the injured worker complained of left sided upper back pain. Objective findings were notable for tenderness of the shoulder joint, positive Hawkins and O'Brien's test. A request for authorization of additional chiropractic therapy 1 x 4 for the left shoulder and left upper back was made. On 01/28/2015, Utilization Review non-certified a request for additional chiropractic therapy 1 x 4 for the left shoulder and left upper back, noting that there was no evidence of an improvement with functional status with the previous therapy received. MTUS guidelines were cited.

IMR ISSUES, DECISIONS AND RATIONALES

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

Chiropractic therapy 1 time a week for 4 weeks for left shoulder and left upper back:

Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines CA Medical Treatment Utilization Schedule (MTUS): The American College of Occupational and Environmental Medicine (ACOEM); 2nd Edition, 2004; CHRONIC PAIN MEDICAL TREATMENT GUIDELINES; Title 8, California Code of Regulations, section 9792.20 et seq. Effective July 18, 2009; 8 C.C.R. 9792.20 - 9792.26 MTUS (Effective July 18, 2009) Page(s): 298-9.

Decision rationale: On 01/28/2015, Utilization Review denied a request for additional Chiropractic care citing CAMTUS Chronic Treatment Guidelines. Following a review of submitted records, the determination is reasonable and supported by cited guidelines. The claimant through the date of request for additional care had completed 20 sessions of Chiropractic care, 11 sessions of Acupuncture and 3 ESWT treatments with submitted reports failing to document objective clinical evidence of functional improvement. The UR determination was appropriate in denying additional treatment, 4 Chiropractic visits. The reviewed records did not address functional improvement or establish the medical necessity for continuing care as required by the CA MTUS Chronic Treatment Guidelines.