

<b>Case Number:</b>	CM15-0049785		
<b>Date Assigned:</b>	03/23/2015	<b>Date of Injury:</b>	04/19/2012
<b>Decision Date:</b>	05/01/2015	<b>UR Denial Date:</b>	03/12/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	03/16/2015

### 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 65 year old female who sustained an industrial injury on 4/19/12 from misplaced desk height and mouse position resulting in injury to her low back, neck, upper back and bilateral shoulder injuries. She initially received medications and therapy. She currently complains of constant, sharp left shoulder pain and is post-operative for shoulder arthroscopy. She is limited in performing activities of daily living. Medications are Vicodin, Ultram, cyclobenzaprine and Anaprox-DS. Diagnoses include rotator cuff tear (non-traumatic), status post arthroscopic acromioplasty, left distal claviclectomy and rotator cuff repair; impingement syndrome; cervical radiculopathy; lumbosacral strain/sprain. Treatments to date include pain medications, modified activity modification, surgery, shoulder abduction brace, Tempurpedic pillow, transforaminal epidural steroid injection which was not helpful, physical therapy and chiropractic therapy. Diagnostics include-rays of the cervical spine right shoulder (1/30/15); MRI of the right and left shoulders (3/21/14) abnormal findings of complete tear of supraspinatus tendon, osteoarthritis and tendinitis; electromyography/ nerve conduction study of the lower extremities (12/4/12) chronic radiculopathy; MRI of the lumbar spine (10/5/12) revealing bulging discs. In the progress note dated 2/20/15 the treating providers plan of care includes referral for chiropractic treatments for 12 visits and therapeutic goals were discussed with the injured worker.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Chiropractic Treatment x12 sessions:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Manual therapy & manipulation.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines 2009, Manual Therapy and Manipulation Page(s): 58 and 59.

**Decision rationale:** The medical records reflect treating diagnoses of rotator cuff tear (non-traumatic), status post arthroscopic acromioplasty, left distal claviclectomy and rotator cuff repair; impingement syndrome; cervical radiculopathy; lumbosacral strain/sprain arising from the 4/19/12 date of injury. The UR determination of 3/12/15 reported the absence of any prior Chiropractic utilization to manage reported spinal/extremity deficits recommending an initial trial of care, 6 visits of the 12 requested. The reviewed medical records do support the medical necessity for Chiropractic care but the 12 visits do exceed California MTUS Chronic Treatment Guidelines; the modified plan of care is reasonable and consistent with referenced guidelines. Therefore, this request is not medically necessary.