

Case Number:	CM15-0237449		
Date Assigned:	12/14/2015	Date of Injury:	03/13/2001
Decision Date:	01/21/2016	UR Denial Date:	11/05/2015
Priority:	Standard	Application Received:	12/04/2015

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

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 52 year old male who sustained an industrial injury on 03-13-2001. A review of the medical records indicated that the injured worker is undergoing treatment for right shoulder rotator cuff tendinosis, biceps tendonitis, cervicobrachial syndrome, cervical and lumbar degenerative disc disease. The injured worker has a history of complex regional pain syndrome. The injured worker is status post open reduction internal fixation of left ulnar fracture, removal of hardware, distal radioulnar joint arthrotomy and excision of scar tissue in 02-2014 and left lateral epicondyle fasciotomy and common extensor tendon repair, left elbow with removal of hardware and repair of mal-union with autogenous bone graft on 02-06-2015. According to the treating physician's progress report on 09-09-2015, the injured worker was evaluated for right shoulder and left upper extremity pain due to an incident occurring on 08-30-2015 when the injured worker reached for a bottle and felt a pop and sharp pain in the anterior aspect of the right shoulder with an immediate deformity of the right upper extremity and periodic numbness and tingling in the ring and small fingers of the right hand. A diagnostic ultrasound performed on 09-09-2015 noted a right biceps tendon rupture. According to the primary treating physician's progress report on 10-10-2015 the injured worker was evaluated for flare-ups of neck, upper back and low back pain. The injured worker rated his neck pain levels at 3-5 out of 10, upper back at 3-4 and lower back at 5 out of 10 on the pain scale. Examination demonstrated cervical tenderness on the left with hypertonicity and at the cervical spinous levels C2, C5 and C7. The bilateral trapezius, suboccipital and thoracic region were also tender. The lumbar examination noted palpable tenderness at the right lumbar region and right erector spinae,

the spinous process at L3, L4 and L5 and the sacroiliac on the right. The injured worker received treatment and was taught and practiced exercises. According to the medical records the injured worker has had approximately 13 chiropractic therapy sessions for flare-ups since 04-03-2015. Prior treatments have included diagnostic testing, multiple surgeries, physical therapy, left stellate ganglion blocks, and right shoulder biceps tendon sheath steroid injection in 04-2015, chiropractic therapy, home exercise program and medications. Current medications were listed as Percocet, Voltaren gel and Ketamine troche. Treatment plan consists of the current retrospective request for chiropractic treatments Qty: 3 (Retrospective DOS: 09-24-15, 09-29-15, and 10-06-15). On 11-05-2015 the Utilization Review determined the request for chiropractic Treatments Qty: 3 (Retrospective DOS: 09-24-15, 09-29-15, and 10-06-15) was not medically necessary.

IMR ISSUES, DECISIONS AND RATIONALES

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

Chiropractic Treatment (Retro - DOS: 0924/15, 09/29/15, 10/06/15), QTY: 3: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Manual therapy & manipulation.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Manual therapy & manipulation.

Decision rationale: The claimant presented with chronic pain in the neck, back, sacroiliac joint, and ankle. According to the available medical records, the claimant has been treated with chiropractic manipulation for his back periodically for flare-ups. The claimant has had about 13 chiropractic visits completed since 04/03/2015 with the last 2 visits completed on 07/24/2015 and 08/07/2015. Although MTUS guidelines might recommend 1-2 visits every 4-6 months for flare-ups, ongoing maintenance care is not recommended. The request for 3 additional visits also exceeded the guidelines recommendation. Therefore, it is not medically necessary.