

Case Number:	CM14-0134721		
Date Assigned:	08/27/2014	Date of Injury:	12/23/1951
Decision Date:	09/29/2014	UR Denial Date:	07/25/2014
Priority:	Standard	Application Received:	08/21/2014

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. The expert reviewer is Board Certified in Physical Medicine & Rehabilitation, and is licensed to practice in Illinois. 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

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 62 year-old male who reported a work related injury on 02/05/2014 due to a fall. He is diagnosed with a right rotator cuff tear. His past treatment has included 18 sessions of physical therapy and medication. Pertinent diagnostic testing and surgical history were not provided for review. Upon assessment on 07/15/2014, his subjective complaints were constant pain in his shoulders which increased with lifting, reaching, and activity. The objective evaluation revealed tenderness to palpation over the right shoulder joint, a positive impingement sign on the right shoulder, and decreased range of motion of the right shoulder with forward flexion to 135/180 degrees, extension to 20/30 degrees, internal rotation to 40/60 degrees, abduction to 135/180 degrees, and adduction to 25/45 degrees. The treatment plan included chiropractic care, a psych and neurological evaluation, and an MRI of the brain, inner ears, and the right shoulder. A rationale for the request and a request for authorization form were not included in the documentation provided for review.

IMR ISSUES, DECISIONS AND RATIONALES

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

Chiropractor 3 x 4 right shoulder: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

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

Decision rationale: The request is not medically necessary. The California MTUS may recommend chiropractic care for chronic pain if caused by musculoskeletal conditions to achieve objective measurable gains in functional improvement and facilitate progression in the patient's therapeutic exercise program. When appropriate, the time to produce effect with manual therapy is 4 to 6 treatments and the guidelines specify that if chiropractic treatment is going to be effective, there should be some outward sign of subjective or objective improvement within the first 6 visits. It is noted within the documentation that the injured worker had decreased range of motion in the right shoulder and it was noted that he participated in a home exercise program. Therefore, manual therapy would be appropriate based on the guidelines. However, as the guidelines recommend an initial trial of 4-6 visits only to produce effect, the request for Chiropractor 3 x 4 right shoulder would exceed the recommendation for initial manual therapy. Therefore, while the injured worker may benefit from chiropractic care, the number of visits requested would exceed the recommendations within the guidelines, therefore, the request for Chiropractor 3 x 4 right shoulder is not medically necessary.

MRI of the right shoulder: Overturned

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 207-209.

Decision rationale: The request is medically necessary. The California MTUS/ACOEM Guidelines state special studies are not needed for patients with shoulder complaints, unless a four- to six-week period of conservative care and observation fails to improve symptoms. The criteria for imaging include the emergence of a red flag; physiologic evidence of tissue insult or neurovascular dysfunction; failure to progress in a strengthening program intended to avoid surgery; or for clarification of the anatomy prior to an invasive procedure. The injured worker was noted to have tried and failed an adequate course of initially recommended conservative treatment, including 18 visits of physical therapy. He has persistent symptoms and increased pain with lifting, reaching, and activity. Additionally, he had positive impingement signs, tenderness to palpation, and significantly decreased range of motion on physical examination. The documentation provides a clear evidence of rotator cuff dysfunction, persistent symptoms, and failed conservative treatment. Therefore, the request for a MRI of the right shoulder is medically necessary.