

Case Number:	CM15-0040416		
Date Assigned:	03/19/2015	Date of Injury:	04/30/2010
Decision Date:	04/20/2015	UR Denial Date:	02/04/2015
Priority:	Standard	Application Received:	03/03/2015

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 59 year old male, who sustained an industrial injury. He reported left knee injury. The injured worker was diagnosed as having bilateral shoulder impingement, rule out bilateral carpal tunnel syndrome, lumbar degenerative disc disease, internal derangement/chondromalacia, left knee and bilateral pes planus/plantar fasciitis. Treatment to date has included physical therapy, left knee arthroscopy with insertion of pain pump and right shoulder arthroscopy. (MRI) magnetic resonance imaging of left knee, (MRI) magnetic resonance imaging of lumbar spine and (MRI) magnetic resonance imaging of right shoulder were performed. Currently, the injured worker complains of left knee and right shoulder pain. The injured worker has received physical therapy in the past with tremendous gains in his pain level.

IMR ISSUES, DECISIONS AND RATIONALES

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

Chiropractic Treatment 1 x 12: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines manual therapy and manipulation.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Manual Therapy is widely used in the treatment of musculoskeletal pain. The intended goal or effect of

Manual Medicine is the achievement of positive symptomatic or objective measurable gains in functional improvement that facilitate progression in the patient's therapeutic exercise program and return to productive activities. Low back: Recommended as an option. Therapeutic care ? Trial of 6 visits over 2 weeks, with evidence of objective functional improvement, total of up to 18 visits over 6-8 weeks. Elective/maintenance care: Not medically necessary. Recurrences/flare-ups: Need to re-evaluate treatment success, if RTW achieved then 1-2 visits every 4-6 months
Page(s): 58-59.

Decision rationale: The claimant presented with chronic pain in the left knee, shoulders, and low back. Previous treatments for the low back include medications, physical therapy, and chiropractic. There are limited document of a recent flare up and evidences based MTUS guidelines do not recommend maintenance care. Therefore, the request for chiropractic treatment once a month for the next 12 months is not medically necessary.