

<b>Case Number:</b>	CM15-0046541		
<b>Date Assigned:</b>	03/18/2015	<b>Date of Injury:</b>	04/01/2003
<b>Decision Date:</b>	04/23/2015	<b>UR Denial Date:</b>	02/19/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	03/11/2015

### 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: Chiropractic

### 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 61 year old female, who sustained an industrial injury on 04/01/2003. Initial complaints reported included left shoulder pain radiating to the neck and down the left upper extremity. The injured worker was diagnosed as having left shoulder strain/sprain. Treatment to date has included conservative care, medications, numerous physical therapy sessions, left shoulder surgery (06/17/2005), left bicipital tendon injection, chiropractic care, psychiatric therapy treatments, x-rays and MRIs of the left shoulder and cervical spine. Currently, the injured worker complains of left shoulder pain. Current diagnoses include left rotator cuff tendinosis, left bicipital tendinosis, left subacromial bursitis, left carpal tunnel syndrome, left ulnar neuritis, myofascial pain syndrome. The treatment plan consisted of 6 chiropractic treatments for the cervical spine. The PTP is requesting 6 additional sessions of chiropractic care to the cervical spine and left shoulder and scapula.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Six (6) chiropractic sessions:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 205. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG).

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Manual Therapy and Manipulation Page(s): 58. Decision based on Non-MTUS Citation ODG Neck & Upper Back Chapter and Shoulder Chapter, Manipulation Sections/MTUS Definitions page 1.

**Decision rationale:** The patient has received prior chiropractic care for her injuries. The MTUS Chronic Pain Medical Treatment Guidelines recommends additional manipulative care with evidence of objective functional improvement. The ODG Neck & Upper Back Chapter for Recurrences/flare-ups states: "Need to re-evaluate treatment success, if RTW achieved then 1-2 visits every 4-6 months when there is evidence of significant functional limitations on exam that are likely to respond to repeat chiropractic care." The MTUS-Definitions page 1 defines functional improvement as a "clinically significant improvement in activities of daily living or a reduction in work restrictions as measured during the history and physical exam, performed and documented as part of the evaluation and management visit billed under the Official Medical Fee Schedule (OMFS) pursuant to Sections 9789.10-9789.11; and a reduction in the dependency on continued medical treatment." The ODG Shoulder Chapter recommends a limited number of chiropractic care sessions to the shoulder, mainly 9 sessions of manipulative care over 8 weeks. The patient has completed these visits. The PTP describes some Improvements with treatment but no objective measurements are presented. The treating chiropractor's records are thorough and complete as seen in the materials provided, Pain levels and range of motion are documented. However the range of motion studies and pain levels are constant with the treatment rendered. Conservative care has failed and thus the patient has been injected for the left shoulder. The records provided by the treating chiropractor do not show objective functional improvements with ongoing chiropractic treatments rendered as outlined by the MTUS definitions. I find that the 6 additional chiropractic sessions requested to the cervical spine and left shoulder to not be medically necessary and appropriate.