

<b>Case Number:</b>	CM15-0066476		
<b>Date Assigned:</b>	04/14/2015	<b>Date of Injury:</b>	04/15/2014
<b>Decision Date:</b>	05/18/2015	<b>UR Denial Date:</b>	03/03/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	04/07/2015

### 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: North Carolina  
 Certification(s)/Specialty: Family Practice

### 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 58 year old female, who sustained an industrial injury on 4/15/2014. Diagnoses include lumbosacral radiculopathy, shoulder impingement and hip tendinitis/bursitis. Treatment to date has included medications, injections and diagnostics. She underwent a right rotator cuff repair on 3/20/2015. Per the Primary Treating Physician's Progress Report dated 11/26/2014, the injured worker reported chronic pain of the right shoulder, left hip and left knee. Physical examination revealed an antalgic gait with pain in the left hip. Discomfort with pain is noted upon elevation of the shoulders bilaterally against gravity at approximately 95 degrees. Impingement is positive bilaterally, mostly on the right side. Greater trochanteric tenderness is noted on the left side with discomfort on flexion and extension of the left hip against gravity and medial joint line tenderness. The plan of care included refill of medications. Authorization was requested for physio/chiro sessions 2-3 times per week 6 weeks.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Physiocardio sessions, twice weekly for three weeks:** 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 manipulation Page(s): 58-59.

**Decision rationale:** The California chronic pain medical guidelines section on manual manipulation states: Recommended for chronic pain if caused by musculoskeletal conditions. 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. Manipulation is manual therapy that moves a joint beyond the physiologic range-of-motion but not beyond the anatomic range-of-motion. 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 reevaluate treatment success, if RTW achieved then 1-2 visits every 4-6 months. Ankle & Foot: Not recommended. Carpal tunnel syndrome: Not recommended. Forearm, Wrist, & Hand: Not recommended. Knee: Not recommended. Treatment Parameters from state guidelines: Time to produce effect: 4 to 6 treatments Manual manipulation is recommended form of treatment for chronic pain. However the requested amount of therapy sessions is in excess of the recommendations per the California MTUS. The California MTUS states there should be not more than 6 visits over 2 weeks and documented evidence of functional improvement before continuation of therapy. The request is for greater than 6 sessions. This does not meet criteria guidelines and thus is not certified. The request IS NOT medically necessary.