

<b>Case Number:</b>	CM14-0074611		
<b>Date Assigned:</b>	07/16/2014	<b>Date of Injury:</b>	08/24/2012
<b>Decision Date:</b>	09/23/2015	<b>UR Denial Date:</b>	05/12/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	05/22/2014

### 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. 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: Physical Medicine & Rehabilitation, Pain Management

### 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 66 year old male, who sustained an industrial injury on 08-24-2012. He has reported injury to the bilateral shoulders. The diagnoses have included bilateral shoulder degenerative joint disease; left shoulder rotator cuff tear; and status post right rotator cuff repair, on 03-11-2013. Treatment to date has included medications, diagnostics, injection, physical therapy, home exercise program, chiropractic therapy, and surgical intervention. A progress report from the treating physician, dated 04-25-2014, documented a follow-up visit with the injured worker. The injured worker reported that he continues to have bilateral shoulder pain. Objective findings included positive crepitation; positive impingement; positive Hawkins test; limited range of motion; and it is noted that the qualified medical evaluation recommended injections, chiropractic, and a new shoulder MRI. The treatment plan has included the request for chiropractic 2x a week for 6 weeks, left shoulder

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Chiropractic 2x a week for 6 weeks, left shoulder:** 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  
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**Decision rationale:** Regarding the request for additional chiropractic care, Chronic Pain Medical Treatment Guidelines support the use of chiropractic care for the treatment of chronic pain caused by musculoskeletal conditions. Guidelines go on to recommend a trial of up to 6 visits over 2 weeks for the treatment of low back pain. With evidence of objective functional improvement, a total of up to 18 visits over 6 to 8 weeks may be supported. Within the documentation available for review, there is documentation of completion of prior chiropractic sessions, but there is no documentation of specific objective functional improvement with the previous sessions and remaining deficits that cannot be addressed within the context of an independent home exercise program, yet are expected to improve with formal supervised therapy. Furthermore, it is unclear how many therapy sessions the patient has already undergone making it impossible to determine if the patient has exceeded the maximum number recommended by guidelines for their diagnosis. In the absence of clarity regarding the above issues, the currently requested chiropractic care is not medically necessary.