MAXIMUS Federal Services

Case Number:	CM13-0006456		
Date Assigned:	02/05/2014	Date of Injury:	03/06/2002
Decision Date:	04/23/2014	UR Denial Date:	07/09/2013
Priority:	Standard	Application Received:	08/02/2013

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 licensed in Chiropractic, and is licensed to practice in Texas. 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 patient is a 50-year-old female who reported an injury on 03/06/2002. The mechanism of injury was not provided. The note dated 04/17/2013 indicated the patient had improvement as expected. The patient reported having residual pain at the right side of the back of her head with neck, upper back radiating to the right posterior and interior shoulder/arm. The patient rated her pain at a 5/10 to 6/10 depending on the activities that had been performed. The subjective improvements that had been made with the previous chiropractic care was decreased pain from a constant 8/10 to 10/10 down to a frequent 5/10 to 6/10 depending on use; increased mobility of the head and neck on the right shoulder with ADL; increased ability to use her injured body parts with daily activities; decreased use of her medication down to occasional use; the patient rated her improvement at 30%; and the ability to sleep better every night. Upon examination the active range of motion of the cervical spine was flexion at 42 degrees, extension at 52 degrees, right rotation at 70 degrees, left rotation at 74 degrees, right lateral at 38 degrees, left lateral at 41 degrees. The range of motion of the right shoulder was flexion at 165 degrees, extension at 42 degrees, abduction at a 165 degrees, adduction at 42 degrees, internal rotation at 78 degrees, and external rotation at 77 degrees. The objective improvements that were noted since previous chiropractic care was increased cervical spine and right shoulder mobility; increased ability to use injured area with less pain; increased muscular strength; decreased pain medication use; and increased ability to keep up with ADLs.

IMR ISSUES, DECISIONS AND RATIONALES

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

CHIROPRACTIC THERAPY ONE (1) TIME PER WEEK FOR SIX (6) WEEKS.: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines PHYSICAL MEDICINE Page(s): 98-99.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines MANUAL THERAPY & MANIPULATION Page(s): 58.

Decision rationale: The request for chiropractic therapy one (1) time per week for six (6) weeks is non-certified. The California MTUS states that manual therapy and manipulation are recommended for chronic pain if caused by musculoskeletal conditions. The intended goal or effect of manual medicine is the achievement of positive symptomatic or objective measurable gains and functional improvement that facilitate progression in the patient's therapeutic exercise program and return to productive activities. Therapeutic care is recommended trial of 6 visits over 2 weeks, with evidence of objective functional improvement, total of up to 18 visits over 6 to 8 weeks. Recurrence/flare-up there needs to be a re-evaluation of treatment success, if return to work is achieved then 1 to 2 visits every 4 to 6 months. The records submitted for review included documentation from 04/17/2013 that the patient had both subjective and objective improvements with chiropractic therapy. However, the records submitted for review failed to indicate the number of visits the patient had received of chiropractic care to date. In addition, the records submitted for review failed to include documentation of recent objective functional deficits to support additional chiropractic care. As such, the request for chiropractic therapy as such, the request for chiropractic therapy one (1) time per week for six (6) weeks is not supported. Therefore, the request is non-certified.