MAXIMUS Federal Services

Case Number:	CM13-0022516		
Date Assigned:	06/06/2014	Date of Injury:	09/12/2012
Decision Date:	07/25/2014	UR Denial Date:	08/08/2013
Priority:	Standard	Application Received:	09/10/2013

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 Board Certified in Chiropractor Care and Acupunture 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 injured worker is a 43-year-old male who reported an injury 09/12/2012. The mechanism of injury was not provided within the medical records. The clinical note, dated 08/01/2013, indicated diagnoses of cervical disc disease, left shoulder arthropathy/rotator cuff tear, and thoracic strain/thoracic disc disease. The injured worker reported he was administered a cortisone injection to the left shoulder which worsened symptoms and increased left shoulder pain and he was unable to lift his arm. The injured worker reported neck pain that was present with numbness and tingling of the left upper limb, arm, and hand. The injured worker reported his symptoms were reduced with rest and ibuprofen, while any lifting or overhead work aggravated the pain. The injured worker reported his pain level as 8/10. On physical examination of the cervical spine, range of motion was reduced 50%, left shoulder range of motion forward flexion was 90, extension was 10, abduction was 80, adduction was 10, external rotation was 40, internal rotation was 10. There was a positive impingement sign and a positive crepitus. The injured worker's motor examination of the upper extremities was normal, as well as stretch reflexes. The injured worker's prior treatments included diagnostic imaging, completion of 18 sessions of chiropractic therapy, and medication management. The provider submitted request for chiropractic therapy. A request for authorization was not submitted for review to include the date the treatment was requested.

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 A WEEK FOR SIX (6) WEEKS FOR THE THORACIC SPINE: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Manual therapy & manipulation Page(s): 58.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Manual therapy & manipulation Page(s): 58-59.

Decision rationale: The California Chronic Pain Medical Treatment Guidelines state Manual Therapy is widely used in the treatment of musculoskeletal pain. Manipulation is manual therapy that moves a joint beyond the physiologic range-of-motion but not beyond the anatomic range-of-motion. 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. The guidelines also state extended durations of care beyond what is considered maximum may be necessary in cases of re-injury, interrupted continuity of care, exacerbation of symptoms, and in those patients with comorbidities. Such care should be re-evaluated and documented on a monthly basis. The injured worker has completed 18 sessions of chiropractic therapy. There was lack of documentation to include lack of efficacy and functional improvement from the prior use of chiropractic therapy. The guidelines state extended duration of care beyond what is considered maximum may be necessary in cases of re-injury, interrupted continuity of care, or exacerbation of symptoms. The documentation submitted did not indicate the injured worker had findings that would suggest re-injury, interrupted continuity of care, or exacerbation of symptoms. Therefore, the request for chiropractic therapy 1 time a week for 6 weeks for thoracic spine is not medically necessary and appropriate.