

Case Number:	CM13-0036088		
Date Assigned:	12/13/2013	Date of Injury:	08/06/2001
Decision Date:	02/07/2014	UR Denial Date:	09/27/2013
Priority:	Standard	Application Received:	10/18/2013

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 California. 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:

According to the available medical records, this is a 66 year old male patient with chronic hands, elbow, shoulders and neck pain, date of injury 08/07/2001. Previous treatments include C5 to C7 anterior cervical discectomy and fusion in 2006, left shoulder subacromial decompression with labral and rotator cuff debridement with biceps tenodesis, patient is permanent and stationary as of 08/08/2012 with future medical care left open for the neck and bilateral upper extremities. Progress report dated 09/03/2013 revealed pain bilateral shoulders (Left more than Right), bilateral elbow pain with Numbness and Tingling to the 4th & 5th digits, 2 months history of Lumbosacral symptoms denies any new trauma; diagnosis is bursitis of shoulder.

IMR ISSUES, DECISIONS AND RATIONALES

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

Chiropractic Treatment, one time a week for six weeks for the Lumbar spine: 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 Page(s): 58 & 59.

Decision rationale: MTUS Chronic Pain, page 58-59, recommended manipulation 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. For Low back region it is 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 week. Elective/maintenance care isn't medically necessary. Recurrences/flare-ups, need to re-evaluate treatment success, if Return to Work achieved then 1-2 visits every 4-6 months. Review of the available medical records do not show this patient's low back pain is chronic ,there was no exam findings or functional loss documented. Therefore, the request for chiropractic treatment one time a week for six weeks for the lumbar spine is not medically necessary.