

Case Number:	CM13-0070083		
Date Assigned:	01/03/2014	Date of Injury:	05/25/2012
Decision Date:	06/05/2014	UR Denial Date:	11/26/2013
Priority:	Standard	Application Received:	12/24/2013

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 Chiropractics 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 69 year old female who reported an injury on 05/25/2012 secondary to an assault. The diagnoses include cervical spine disc disease, facet syndrome and radiculopathy, right shoulder sprain/strain and right sided carpal tunnel syndrome. The injured worker was evaluated on 10/13/2013 for reports of right sided shoulder stabbing, burning, tingling and ripping apart pain rated at 9/10 and radiating up to head and down to right arm with a pulling sensation. The exam noted right shoulder range of motion was abduction 160 degrees, flexion 170 degrees, internal rotation 80 degrees, crossed shoulder 30 degrees. A right sided positive Tinel sign, decreased sensation along the C5-6 dermatomes was also noted. The treatment plan included cervical facet injection, EMG/NCV of the upper extremities, NSAIDs and an EMS unit. The request for authorization was not found in the documentation provided.

IMR ISSUES, DECISIONS AND RATIONALES

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

CHIROPRACTIC TWICE A WEEK FOR SIX WEEKS FOR THE NECK AND THORACIC SPINE: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 58-59.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Manual Therapy and Manipulation Page(s): 58-60.

Decision rationale: The request for chiropractic twice a week for six weeks for the neck and thoracic spine is not medically necessary. The California MTUS Chronic Pain Medical Treatment Guidelines recommend manual therapy and manipulation for chronic pain caused by musculoskeletal conditions of the low back. The request is for therapy for the thoracic and neck areas. Furthermore, there is no evidence in the documentation provided of the intended use of chiropractic care and rationale. In addition, the request for 12 visits exceeds the California Medical Treatment Utilization Schedule recommendations of an initial trial of 6 visits. Therefore, the request is not medically necessary or appropriate.