MAXIMUS Federal Services

Case Number:	CM14-0007595		
Date Assigned:	02/10/2014	Date of Injury:	05/23/1999
Decision Date:	06/24/2014	UR Denial Date:	12/19/2013
Priority:	Standard	Application Received:	01/21/2014

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. The expert reviewer is Board Certified in Chiropractic Medicine and is licensed to practice in California and 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:

According to the 152 pages of submitted documentation, the injured worker (IW), a 71 year old female, reported neck/low back/shoulder pain on 5/3/99. Mechanism of injury is not stated. The treatment to be addressed in this review is chiropractic care 12 sessions for the cervical spine. The IW is status post surgical repair bilaterally for rotator cuff tear on 12/3/07. Electro-diagnostic studies were essentially normal on 4/5/11. The report dated 1/10/14 by [redacted]. noted restricted range of motion in the cervical and lumbar spine, restricted ROM in flexion/abduction in shoulders, and a positive Impingement sign. The report dated 2/14/14 by [redacted] noted restricted range of motion in the cervical and lumbar spine, restricted ROM in flexion/abduction in shoulders, positive Impingement sign. Report dated 3/4/14 noted sharp pain in lower posterior neck radiating to the interscapular muscles, and decreased cervical range of motion. Report dated 3/6/14 noted "pain and severe weakness in all of her body." The report dated 3/14/14 by [redacted]. noted restricted range of motion in the cervical and lumbar spine, restricted ROM in flexion/abduction in shoulders, and positive Impingement sign.

IMR ISSUES, DECISIONS AND RATIONALES

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

CHIROPRACTIC TREATMENT THREE (3) TIMES A WEEK FOR FOUR (4) WEEKS FOR THE NECK, SHOULDERS AND BACK: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation MTUS: CHRONIC PAIN MEDICAL TREATMENT GUIDELINES, MANUAL THERAPY & MANIPULATION, 58-61

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation MTUS: CHRONIC PAIN MEDICAL TREATMENT GUIDELINES PHYSICAL MEDICINE, , 58-61

Decision rationale: The MTUS Guidelines indicate that a trial of chiropractic care is appropriate with additional treatment based on significant improvement. The IW is noted as having received a trial of 4 sessions of chiropractic care. Review of [redacted] reports dated 1/10/14, 2/14/14, and 3/6/14 revealed no change in clinical findings. The daily office visits provide no clinical findings such as range of motion, orthopedic test results, or specific sensory/motor deficits. There is no specific flare up noted or the date of alleged flare up. There are no red-flags or compelling rationale for the requested supervised therapy over a self-directed home exercise program at this time. There is no documentation of any noted gains in clinical findings following the trial of care. Given the lack of clinical findings noting significant gains, it is the opinion of this reviewer that the proposed chiropractic treatment of 12 sessions is not medically necessary and not in keeping with the guidelines.