

Case Number:	CM14-0015910		
Date Assigned:	04/23/2014	Date of Injury:	12/04/2013
Decision Date:	07/02/2014	UR Denial Date:	01/14/2014
Priority:	Standard	Application Received:	02/07/2014

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 a licensed Doctor of 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:

The patient is a 52year old female who was injured on 02/22/2006. The patient was involved in a motor vehicle accident and as a result had complaints of back, bilateral shoulder and bilateral knee pain. On 04/03/2013 she suffered from sprain/strain, overuse like syndrome. On 12/03/2013 her condition got worse and she requested to be taken off work. First Report of Occupational Injury or Illness dated 12/18/2013 documents the following subjective complaints:1. Neck pain radiating to the bilateral upper extremities. 2. Mid back pain. 3. Low back pain. 4. Bilateral shoulder pain. 5. Bilateral elbow/forearm pain. 6. Bilateral wrist/hand pain. 7. Bilateral knee pain. 8. Bilateral ankle/foot pain. 9. Stomach pain. 10. Sleeping difficulties. 11. Headaches. 12. Stress, anxiety and depression. Objective findings on exam of the cervical spine reveal tenderness to palpation is present. Range of motion of the cervical spine is decreased. Examination of the lumbar spine reveals lumbar lordotic curvature. Tenderness to palpation is present. Straight leg raising produces localized pain. Range of motion of the lumbar spine is decreased. Examination of bilateral shoulders reveals tenderness to palpation is present. There is subacromial crepitus with passive ranging. Impingement and cross arm testing is positive bilaterally. Range of motion of the shoulders is decreased. Treatment Plan: Further treatment is required. Chiropractic treatment three times per week for four weeks to decrease pain and increase range of motion and ability to perform activities of daily living. Therapy Services Evaluation dated 01/29/2014 documents the patient's fifth visit since 01/20/2014. Continue rehab exercises with physical therapy modality to restore range of motion, strength and ADLs. PR-2 dated 03/14/2014 documented the patient to have complaints of right shoulder pain. Her pain level was reported 8/10 without meds, 4-5/10 with meds with a duration of relief of six hours. Since the last follow up visit (01/31/2014) the patient underwent additional chiropractic treatment (12 sessions to date) with RPTD. There was

a benefit of increased mobility of the right shoulder and thoracic/lumbar spine. The patient also performed HEP. The remainder of the exam is illegible.

IMR ISSUES, DECISIONS AND RATIONALES

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

CHIROPRACTIC TREATMENT 3 X 4 DIRECTED TO THE CERVICAL SPINE, THORACIC SPINE, LUMBAR SPINE, BILATERAL SHOULDER, BILATERAL ELBOWS, BILATERAL WRIST BILATERAL KNEES AND BILATERAL ANKLES:

Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 298-299.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Manual therapy & manipulation Page(s): 58-60.

Decision rationale: Pursuant to the CA MTUS Chronic Pain Medical Treatment Guidelines, and regarding treatment request for cervical, thoracic spine, shoulders and elbows an initial treatment session of 6 visits over a period of 2 weeks is recommended if pain is musculoskeletal in origin with a total of 18 visits over a 6-8 week period provided there is clear documentation of a measurable improvement in functional capacity with a goal of transitioning the patient to a home exercise program. Per the guidelines, Effective/maintenance care- is not medically necessary. Flare-ups -Need to reevaluate treatment success. If RTW is achieved, then 1-2 visits every 4-6 months. This request fall outside the 6-8 week period addressed within the guidelines. Therefore request for Chiropractic 3 visits x 4 weeks is non-certified.