

| | | | |
|-----------------------|--------------|------------------------------|------------|
| Case Number: | CM14-0017358 | | |
| Date Assigned: | 04/14/2014 | Date of Injury: | 01/31/2013 |
| Decision Date: | 05/30/2014 | UR Denial Date: | 02/06/2014 |
| Priority: | Standard | Application Received: | 02/11/2014 |

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 licensed in Chiropractic Services 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 49-year-old male who reported an injury on 01/31/2013. The mechanism of injury was not stated. Current diagnoses include closed fracture of the clavicle, lesion of the ulnar nerve, numbness, cervical stenosis, cervical spondylosis, and cervical radiculopathy. The injured worker was evaluated on 08/21/2013. The injured worker reported temporary relief following massage therapy and physical therapy. Physical examination revealed midline tenderness at C6-T1 and T1-T5, paracervical tenderness, general stiffness without radicular pain, tenderness at the right inferolateral ribs, full shoulder range of motion, decreased sensation to light touch in the radial nerve distribution, and decreased sensation to light touch in the ulnar distribution on the right with positive Tinel's testing. Treatment recommendations included a referral for chiropractic treatment.

IMR ISSUES, DECISIONS AND RATIONALES

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

CHIROPRACTIC 2 X 6 TO THE CERVICAL, THORACIC AND LOW BACK AND THEN RE-EXAM: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Manual Therapy And Manipulation.

MAXIMUS guideline: Decision based on MTUS ACOEM,Chronic Pain Treatment Guidelines.

Decision rationale: California MTUS Guidelines state manual therapy and manipulation is recommended if caused by a musculoskeletal condition. Treatment for the spine is recommended as an option with a therapeutic trial of 6 visits over 2 weeks. Therefore, the current request for 12 sessions of chiropractic therapy exceeds guideline recommendations. As such, the request is not medically necessary and appropriate.