

Case Number:	CM14-0135822		
Date Assigned:	09/03/2014	Date of Injury:	11/02/2010
Decision Date:	11/14/2014	UR Denial Date:	07/21/2014
Priority:	Standard	Application Received:	08/25/2014

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 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 45 year old female who was injured on 11/02/2010 when she slipped and fell. Progress report dated 07/07/2014 documented the patient to have complaints of persistent headaches, back pain with leg weakness, left wrist pain rated as 2/10 and right knee pain that increases with activity. On exam, the cervical spine revealed tenderness to palpation with any axial compression of the head. Range of motion was improved with forward flexion at 50/60 degrees; extension 35/50 degrees; rotation 60/90 degrees bilaterally. The lumbar spine revealed improved range of motion with forward flexion 65/90 degrees; extension at 15/30. Seated straight leg raise was at 70 degrees bilaterally. The patient was diagnosed with lumbosacral spine sprain/strain; cervical spine sprain/strain; headaches, and lumbosacral spine sprain/strain. Prior utilization review dated 07/21/2014 states the request for Chiropractic Care 2x4 (14 Chiro to Date) is denied as medical necessity has not been established.

IMR ISSUES, DECISIONS AND RATIONALES

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

CHIROPRACTIC CARE 2X4 (14 CHIRO TO DATE): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines MANIPULATION.

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

Decision rationale: The patient is female, age 45 and was injured on 11/2/2010. The records reflect the patient reports and provider documented on (7/7/2014 PR2) persistent headaches/pressure of unknown duration and/or intensity, at the top of her head which increases with physical activities (ADLs) since the date of her injury. She also reports pain of unknown duration and intensity within various other body parts, including her cervical and lumbar spines. The provider has not noted, within the records, any residual functional deficits on this most recent flair-up. The records indicate this patient has had 14 prior Chiropractic treatments to date. This new request for treatment, as reported by the provider, is to treat persistent, unrelenting and unchanged pain within multiple body areas. There is no documentation evidence found within the records indicating specific improvement/gains in functional capacity (ability to perform her ADLs) was accomplished by the prior 14 treatments, which is required by the CA MTUS guidelines prior to additional treatment being considered. Additional, 8 additional visits would exceed the guidelines recommendations of 18 visits over a 6-8 week period. "Per The CA MTUS guidelines, Chiropractic care is recommended 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 the progression in the patient's therapeutic exercise program and return to productive activities. Manipulation is manual therapy that moves a joint beyond the physiologic range-of-motion but not beyond the anatomic range-of-motion. Low back: 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 a 6-8 week. Elective/maintenance care- Not medically necessary. Recurrence/flare-ups- Need to re-evaluate treatment success, if RTW achieved then 1-2 visits every 4-6 months. Ankle & Foot: Not recommended. Carpal tunnel syndrome: Not recommended. Forearm, Wrist, & Hand: Not recommended. Knee: Not recommended". Per the above guidelines, the request for Chiropractic treatments 2x per week for 4 weeks is not medically necessary.