

Case Number:	CM14-0183996		
Date Assigned:	11/10/2014	Date of Injury:	07/23/2014
Decision Date:	12/18/2014	UR Denial Date:	10/03/2014
Priority:	Standard	Application Received:	11/04/2014

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 Chiropractor, has a subspecialty in Acupuncture 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 injured worker is a 36 year old male who reported right shoulder, neck, mid back and low back pain from injury sustained on 07/23/14 due to slip and fall. There were no diagnostic imaging reports. Patient is diagnosed with shoulder sprain/strain; thoracic sprain/strain; lumbar sprain/strain; right upper extremity neuralgia and paraesthesia; intervertebral neuritis and radiculitis. Patient has been treated with medication and chiropractic. Provider requested additional 12 chiropractic visits for right shoulder, neck, mid back and low back. The only medical records available for review was an appeal letter dated 11/17/14. Per appeal letter dated 11/17/14; on 07/30/14 patient complains of moderate to severe right lateral rib pain, right shoulder pain, right clavicular pain and mid back pain. He complains of constant slight to severe neck pain and low back pain. He has constant minimal to slight right arm numbness; Intermittent minimal to slight to moderate right thigh pain. Overall neck pain is rated between 7-9/10 with decreased range of motion and low back pain rated 6-8/10 with decreased range of motion. On 08/18/14, patient complains of frequent minimal to severe right lateral rib pain. He complains of constant minimal to moderate right shoulder pain; frequent minimal to moderate right clavicular pain; constant minimal to moderate mid back, neck and low back pain. He complains of constant slight arm numbness and occasional minimal to slight right thigh pain. Overall neck pain is rated at 6-7/10 and low back pain is rated 5-6/10. Appeal letter demonstrated slight decrease in subjective complains and increase in range of motion. Medical reports reveal little evidence of significant changes or improvement in findings, revealing a patient who has not achieved significant objective functional improvement to warrant additional treatment.

IMR ISSUES, DECISIONS AND RATIONALES

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

Chiropractic therapy treatment to the right shoulder, cervical, lumbar and thoracic spine for 12 sessions, 2 times a week for 6 weeks: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Manual Therapy and Manipulation Page(s): 58-59.

Decision rationale: Per California Medical Treatment Utilization Schedule (MTUS) - Chronic Pain medical treatment guideline - Manual therapy and manipulation Page 58-59.

"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 objectively measurable gains in functional improvement that facilitate progression in the patient's therapeutic exercise program and return to productive activities". 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 6-8 weeks. Elective/ maintenance care- not medically necessary. Re occurrences/ flare-ups- need to re-evaluate treatment success, if return to work (RTW) achieved then 1-2 visits every 4-6 months. Treatment parameters from state guidelines. A) Time of procedure effect: 4-6 treatments. B) Frequency 1-2 times per week the first 2 weeks as indicated by the severity of the condition. Treatment may continue at 1 treatment per week for the next 6 weeks. C) Maximum duration: 8 weeks. At 8 weeks patient should be re-evaluated. Care beyond 8 weeks may be indicated for certain chronic pain patients in whom manipulation has been helpful in improving function, decreasing pain and improving quality of life. Treatment beyond 4-6 visits should be documented with objective improvement in function". Patient has had prior chiropractic treatments; however, clinical notes fail to document any functional improvement with prior care. Provider requested additional 12 chiropractic sessions for right shoulder, neck, thoracic and lumbar spine. The only medical records available for review was an appeal letter dated 11/17/14. Appeal letter demonstrated slight decrease in subjective complains and increase in range of motion Medical reports reveal little evidence of significant changes or improvement in findings, revealing a patient who has not achieved significant objective functional improvement to warrant additional treatment. Per guidelines, functional improvement means either a clinically significant improvement in activities of daily living or a reduction in work restrictions as measured during the history and physical exam. Requested visits exceed the quantity supported by cited guidelines. Per review of evidence and guidelines, 12 Chiropractic visits are not medically necessary.