

Case Number:	CM14-0037985		
Date Assigned:	06/25/2014	Date of Injury:	11/18/2013
Decision Date:	07/28/2014	UR Denial Date:	03/14/2014
Priority:	Standard	Application Received:	04/01/2014

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 Care 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 56-year-old male who was injured on 11/18/2013. The mechanism of injury is unknown. Prior treatment history has included physical therapy. Diagnostic studies reviewed include magnetic resonance imaging (MRI) of the cervical spine dated 11/26/2013 revealed multilevel disc disease from C2 through C6. There is minimal grade I anterolisthesis of C3 on C4 and retrolisthesis of C4 on C5-both measure 1 mm or less. There is mild to moderate bilateral neural foraminal narrowing at C3-C4 and C4-C5. At C5-C6 level, there is moderate left-sided and mild to moderate right-sided neural foraminal narrowing. At C6-C7 level there is mild to moderate bilateral foraminal narrowing. Progress report dated 02/06/2014 indicates the patient complained of neck pain and stiffness. On left rotation of his neck, he gets flare ups of symptoms. He compensates with truncal rotation. It is noted that the patient has received positive benefit from chiropractic therapy in the past. He rated his pain as 7/10. There was no exam for review. Diagnoses are cervical disc disease/cervical stenosis and cervical radicular symptoms. Chiropractic therapy, (8) sessions, has been recommended. No change in symptoms is noted on progress note dated 03/04/2014. Prior utilization review dated 03/14/2014 states the request for Chiro manipulation and rehabilitation times eight is not authorized as the request is not consistent with the guidelines and there is no documentation demonstrating any benefit the patient may have received from this treatment in the past.

IMR ISSUES, DECISIONS AND RATIONALES

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

Chiro manipulation and rehabilitation x 8: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Manual therapy and manipulation. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG); Work Loss Data Institute, LLC; Corpus Christi, TX; www.odg-twc.comACOEM-hrrps://www.acoempracuides.org/.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Chiro manipulation Page(s): 48. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) < Chiropractic treatment >.

Decision rationale: The California Medical Treatment Utilization Schedule (MTUS) guidelines allow for manual therapy on a 6 visit trial basis within the first 2 weeks of an injury with up to 18 visits over the next 6-8 weeks with documentation of the patients improvement in their functional capacity to perform their daily activities of daily living with a goal of transitioning the patient to a home exercise program and eventual return to work. "Per The CA MTUS guidelines, Manual therapy 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."This patient has had Chiropractic treatment with no documentation within the records describing any specific improvement functional capacity this patient has gained with prior treatment nor do the records contain any specific goal/improvement to be attained with future chiropractic care. There is also no mention of the patient participating or having been transitioned to a home exercise program. This decision/request for Chiro manipulation and rehabilitation times eight, does not meet the requirements of the above outlined guidelines and is therefore not medically necessary.