

Case Number:	CM14-0051567		
Date Assigned:	07/07/2014	Date of Injury:	06/25/2013
Decision Date:	08/06/2014	UR Denial Date:	04/14/2014
Priority:	Standard	Application Received:	04/18/2014

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:

According to the available medical records, this is a 48 year old male patient with chronic left shoulder, head and neck pain, date of injury 06/25/2013. Previous treatments include acupuncture, chiropractic, physical therapy, left shoulder injection. Progress report dated 04/01/2014 by the treating doctor revealed frequent/intermittent, moderate pain and soreness in the left shoulder; frequent/intermittent, moderate, radiating pain and stiffness in the neck; frequent/intermittent, moderate head pain; frequent, moderate to severe pain and soreness left elbow/forearm; constant/frequent, moderate to severe pain and soreness left wrist; constant/frequent, moderate to severe pain and stiffness lower back; and constant/frequent, moderate to severe stomach/GI discomfort. Exam of the left shoulder revealed moderate palpable tenderness, ROM, slightly improved, Abd 115/170, flex 115/170, internal rotation 35/60, ext. rotation 45/80, extension 8/30, add. 5/30, positive Appley's scratch, positive Apprehension, Codman's. Cervical exam revealed moderate to severe palpable tenderness, decreased ROM, positive shoulder distraction. Lumbar exam noted moderate to severe palpable tenderness, decreased ROM, positive Kemps, SLR, Ely's, Milgrams, Valsalva, +4/+5 Heel/Toe walk. Left elbow/forearm moderate palpable to severe tenderness, decreased ROM, positive Mills, Cozen's. Left wrist moderate palpable tenderness, decreased ROM, decreased grip strenght, positive Tinel's and Phalen's. Diagnoses include left shoulder tendinosis, cervical multiple disc bulges, lumbar multiple disc bulges, left cubital tunnel syndrome and left wrist/hand sp/st and tendonitis. Treatment plan to include chiropractic and therapeutic exercises until he complete 24 treatments. The patient remained on temporarily totally disabled.

IMR ISSUES, DECISIONS AND RATIONALES

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

Chiropractic treatments; unspecified amount and frequency/duration: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Page(s): 106,111,115,265,339,369,Chronic Pain Treatment Guidelines Page(s): 58.

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

Decision rationale: The Chronic Pain Medical Treatment Guidelines Chronic Pain page 58-59 states: 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 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. Recurrences/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. Treatment Parameters from state guidelines. a. Time to produce effect: 4 to 6 treatments. b. Frequency: 1 to 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. Maximum duration: 8 weeks. At week 8, patients should be reevaluated. Care beyond 8 weeks may be indicated for certain chronic pain patients in whom manipulation is helpful in improving function, decreasing pain and improving quality of life. This patient has had chiropractic treatments prior to this request with no evidence of objective functional improvement. Also, CA MTUS guidelines do not recommend chiropractic treatments for forearm, wrist and hand. Therefore, the request for additional chiropractic treatments to complete 24 treatments of chiropractic care is not medically necessary.