

Case Number:	CM14-0074987		
Date Assigned:	07/16/2014	Date of Injury:	05/08/2002
Decision Date:	09/17/2014	UR Denial Date:	04/25/2014
Priority:	Standard	Application Received:	05/22/2014

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 Chiropractor 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 47-year-old female who reported an injury on 05/08/2002. The mechanism of injury was not provided for clinical review. The diagnoses included lumbar facet syndrome with right shoulder impingement. Previous treatments included medication. Within the clinical note dated 01/20/2014, it was reported the injured worker complained of low back and right shoulder pain. Upon the physical examination, the provider noted the injured worker to tenderness and spasms in the lumbar spine. The range of motion was forward flexion at 30 degrees and extends to neutral. The injured worker had a negative straight leg raise. The provider noted the injured worker had moderate tenderness with positive impingement sign of the right shoulder. The range of motion was forward flexion at 150 degrees and adduction at 150 degrees. The provider requested chiropractic sessions. However, a rationale was not provided for clinical review. The Request for Authorization was not provided for clinical review.

IMR ISSUES, DECISIONS AND RATIONALES

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

Chiropractic sessions 2x6 cervical/thoracic spine: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines: Neck and Upper Back Chapter.

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

Decision rationale: The request for chiropractic sessions 2 times 6 cervical/thoracic spine is not medically necessary. The California Medical Treatment Utilization Schedule (MTUS) Guidelines recommend manual therapy for chronic pain if caused by musculoskeletal conditions. The intended goal of effective manual therapy is the achievement of positive symptoms where objective measurable gains in functional improvement that facilitate progression in the patient's therapeutic exercise program and return to productive activities. The guidelines recommend a trial of 6 visits over 2 weeks and with evidence of objective functional improvement, a total of 18 visits over 6 to 8 weeks. There is lack of documentation regarding a complete physical examination to evaluate for decreased functional ability, decreased strength and flexibility. The requested submitted for 12 chiropractic sessions exceeds the guidelines recommendation of a trial of 6 visits over 2 weeks. Therefore, the request is not medically necessary.