

Case Number:	CM14-0149031		
Date Assigned:	09/18/2014	Date of Injury:	04/24/2002
Decision Date:	04/01/2015	UR Denial Date:	09/05/2014
Priority:	Standard	Application Received:	09/12/2014

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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:

State(s) of Licensure: California

Certification(s)/Specialty: Chiropractic

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 39-year-old female, with a reported date of injury of 04/24/2002. The diagnoses include cervical sprain/strain, thoracic sprain/strain, and lumbosacral sprain/strain. Treatments have included chiropractic treatment and oral medications. The progress report dated 08/13/2014 indicates that the injured worker had increased cervical/thoracic pain, rated 7 out of 10 and bilateral trapezius pain, rated 4 out of 10. The objective findings showed decreased cervical/thoracic range of motion, decreased upper extremity muscle strength due to cervical pain. The treating physician requested a chiropractic evaluation and three sessions to the cervical and thoracic spine, consisting of spinal adjustment, myofascial release, and physical therapy. The rationale for the request was not indicated. On 05/05/2014, Utilization Review (UR) denied the request for a chiropractic evaluation and three sessions to the cervical and thoracic spine, consisting of spinal adjustment, myofascial release, and physical therapy. The UR physician noted that the injured worker was over eleven years post injury with no evidence as to the type and nature of treatment given to the injured worker prior to the request. The MTUS Chronic Pain Guidelines were cited.

IMR ISSUES, DECISIONS AND RATIONALES

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

Chiropractic re-exam x1: Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 58.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation MTUS Definitions page 1/ California Code of Regulations, Title 8, Section 9785.2.

Decision rationale: It is the duty of the Primary Treating Physician to re-examine the patient and monitor his/her progress on a monthly basis as set forth by California Code of Regulations, Title 8, Section 9785.2. The MTUS-Definitions page 1 defines functional improvement as a "clinically significant improvement in activities of daily living or a reduction in work restrictions as measured during the history and physical exam, performed and documented as part of the evaluation and management visit billed under the Official Medical Fee Schedule (OMFS) pursuant to Sections 9789.10-9789.11; and a reduction in the dependency on continued medical treatment." Per The MTUS in order for objective functional improvement to be measured, an examination is necessary. I find that the 1 chiropractic re-exam to be medically necessary and appropriate.

3 chiropractic treatments to cervical and thoracic spine, consisting of spinal adjustment, myofascial release and physical therapy: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 58.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Manual Therapy and Manipulation Page(s): 58. Decision based on Non-MTUS Citation ODG Neck & Upper Back and Low Back Chapters, Manipulation Sections/MTUS Definitions page 1.

Decision rationale: The patient has received prior chiropractic care for her injuries. The MTUS Chronic Pain Medical Treatment Guidelines recommends additional manipulative care with evidence of objective functional improvement. The ODG Neck & Upper Back and Low Back Chapters for Recurrences/flare-ups states: "Need to re-evaluate treatment success, if RTW achieved then 1-2 visits every 4-6 months when there is evidence of significant functional limitations on exam that are likely to respond to repeat chiropractic care." The MTUS-Definitions page 1 defines functional improvement as a "clinically significant improvement in activities of daily living or a reduction in work restrictions as measured during the history and physical exam, performed and documented as part of the evaluation and management visit billed under the Official Medical Fee Schedule (OMFS) pursuant to Sections 9789.10-9789.11; and a reduction in the dependency on continued medical treatment." The PTP describes some Improvements with treatment but no objective measurements are listed. The range of motion is not documented by the treating chiropractor. Work status is not documented and pain intensities on the Visual Analog Scale (VAS) are not listed with each progress note to monitor patient progress. The records provided by the treating chiropractor do not show objective functional improvements with ongoing chiropractic treatments rendered. I find that the 3 additional

chiropractic sessions requested to the cervical and thoracic spine to not be medically necessary and appropriate.