

Case Number:	CM14-0176341		
Date Assigned:	10/29/2014	Date of Injury:	03/05/2012
Decision Date:	02/12/2015	UR Denial Date:	10/20/2014
Priority:	Standard	Application Received:	10/24/2014

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 Chiropractor (DC), 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 patient is addressed as a 54 year old female involved in a automobile/work related accident on 3/5/12. The request for additional Chiropractic care, 6 visits, was not accompanied by reference to the number of completed visits thought the date of report 10/14/14. The reexamination of 10/08/14 found residual deficits on examination including ROM loss in the cervical spine; none in the affected shoulder; positive Hawkin's and Spurling's; regional tenderness over the parathoracic muscle was reported. No sensory or motor deficits were reported. The UR determination of 10/20/14 found no documentation supporting the rationale for additional Chiropractic treatment of the thoracic spine. Prior medical report from [REDACTED] dated 5/12/14 reference the patient receiving prior Chiropractic care and physical therapy as well as injections to the spine. CAMTUS Chronic Pain Medical Treatment Guidelines, title 8; ODG, Work Loss Institute, Neck/Back were used as evidence based support for denial.

IMR ISSUES, DECISIONS AND RATIONALES

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

Additional Chiropractic Care for the Lumbar Spine (Lower Back) Three Times Weekly for Two Weeks: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Web Edition, Low Back Section (www.odg-twc.com)

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Manual Therapy and Manipulation Page(s): 58-59. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Neck and Upper Back

Decision rationale: The reviewed medical records reflect chiropractic treatment referenced by [REDACTED] prior to May 12, 2014 for residual right shoulder pain. The 10/8/14 reexamination from [REDACTED] addresses cervical spine deficits on examination without reference to prior chiropractic care being directed to this region or the affected right shoulder. The California MTUS Chronic Treatment Guidelines supports additional manual therapy/manipulation when evidence of functional improvement is provided after the initial course of manipulation, 6 sessions. "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, performed and documented as part of the evaluation and management visit. There is history of prior chiropractic treatment referenced in the report from [REDACTED] supporting a prior course of manipulation management of either spine or shoulder not expressed by [REDACTED] either in the number of completed visits or what function improvement was documented prior to his request for additional care. The 10/20/14 UR determination to deny further care per reference guidelines was appropriate and commensurate with a lack of documentation supporting prior manipulative care providing required objective evidence of functional improvement. Therefore, this request is not medically necessary.