

Case Number:	CM15-0003436		
Date Assigned:	01/14/2015	Date of Injury:	09/09/2009
Decision Date:	03/25/2015	UR Denial Date:	12/08/2014
Priority:	Standard	Application Received:	01/07/2015

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: Emergency Medicine

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 56 year old female, who sustained an industrial injury on 9/9/2009. On 1/7/15, the injured worker submitted an application for IMR for review of Physical Therapy (Neck/Shoulders) QTY: 8.00, and Chiropractic Treatment (Neck) QTY : 6.00. The treating provider has reported the injured worker complained of ongoing sharp stabbing neck, shoulder and back pain with numbness, tingling and weakness to upper extremities. The diagnoses have included neck strain, carpal tunnel syndrome, and shoulder region pain. Treatment to date has included Cervical Spine MRI (12/17/09), MRI right shoulder and wrist (3/29/11), status post posterior interbody fusion with instrumentation L4-L5 and L5-S1 1/2/12), extracorporeal shockwave therapy x6 to each shoulder, physical therapy, and chiropractic care. On 12/8/14 Utilization Review non-certified Physical Therapy (Neck/Shoulders) QTY: 8.00, and Chiropractic Treatment (Neck) QTY: 6.00. The MTUS, ODG and ACOEM Guidelines were cited.

IMR ISSUES, DECISIONS AND RATIONALES

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

Physical Therapy (Neck/Shoulders) QTY : 8.00: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 173-174, Chronic Pain Treatment Guidelines Physical Medicine Page(s): 9, 99. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Physical Therapy Guidelines

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 181. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Neck and Upper Back, Acute and Chronic, Physical therapy

Decision rationale: The requested Physical Therapy (Neck/Shoulders) QTY : 8.00, is not medically necessary. American College of Occupational and Environmental Medicine (ACOEM), 2nd Edition, (2004), CHAPTER 8, Neck and Upper Back Complaints, summary of Recommendations and Evidence, Page 181; and Official Disability Guidelines (ODG), Neck and Upper Back, Acute and Chronic, Physical therapy, recommend continued physical therapy with documented objective evidence of derived functional benefit. The injured worker has neck, shoulder and back pain with numbness, tingling and weakness to upper extremities. The treating physician has not documented sufficient objective evidence of derived functional benefit from completed physical therapy sessions, or the medical necessity for additional physical therapy to accomplish a transition to a dynamic home exercise program. The criteria noted above not having been met, Physical Therapy (Neck/Shoulders) QTY: 8.00 is not medically necessary.

Chiropractic Treatment (Neck) QTY : 6.00: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Page(s): 9, 99.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Manual Therapy and Manipulation, Pages 58-60 Page(s): 58-60.

Decision rationale: The requested Chiropractic Treatment (Neck) QTY : 6.00 , is not medically necessary. CA MTUS Chronic Pain Treatment Guidelines, Manual Therapy and Manipulation, Pages 58-60, recommend continued chiropractic therapy with documented derived functional improvement. The injured worker has neck, shoulder and back pain with numbness, tingling and weakness to upper extremities. The treating physician has not documented objective evidence of derived functional improvement from completed chiropractic sessions. The criteria noted above not having been met, Chiropractic Treatment (Neck) QTY: 6.00 is not medically necessary.