

Case Number:	CM15-0136318		
Date Assigned:	07/24/2015	Date of Injury:	01/15/2014
Decision Date:	08/20/2015	UR Denial Date:	07/10/2015
Priority:	Standard	Application Received:	07/14/2015

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: North Carolina
 Certification(s)/Specialty: Family Practice

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 (IW) is a 39-year-old female who sustained an industrial injury 01/15/2014. Diagnoses/impressions include cervical/CADS (cervical acceleration/deceleration syndrome) injury; thoracic sprain/strain; and lumbar sprain/strain. Treatment to date has included medications and chiropractic care with physiotherapy. According to the progress notes dated 6/24/15, the IW reported increased numbness and tingling in the hands and neck pain, headaches and loss of sleep. On examination, there was pain at C5 through C7 bilaterally. Foraminal compression test was positive bilaterally. Soto-Hall test and cervical distraction test was positive; Tinel's and Phalen's signs were positive; and there was sensory loss in the C5-C7 dermatomes on the right. A request was made for six chiropractic treatments for the cervical spine, thoracic spine and lumbar spine and pain management visits once per month for medication management.

IMR ISSUES, DECISIONS AND RATIONALES

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

Chiropractic treatments for the cervical spine, thoracic spine, and lumbar spine Qty: 6:
 Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines.

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

Decision rationale: The California chronic pain medical guidelines section on manual manipulation 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. Manipulation is manual therapy that moves a joint beyond the physiologic range-of-motion but not beyond the anatomic range-of-motion. 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 reevaluate 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. Manual manipulation is recommended form of treatment for chronic pain. However the requested amount of therapy sessions is in excess of the recommendations per the California MTUS. The California MTUS states there should be not more than 6 visits over 2 weeks and documented evidence of functional improvement before continuation of therapy. The patient has had previous chiropractic care without documented objective improvements in pain and function. Therefore, the request is not medically necessary.

Pain Management visits once per month for medical management: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG)- TWC Pain Procedure Summary Online Version last updated 06/15/2015.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) medical reevaluation.

Decision rationale: The ACOEM and the California MTUS do not specifically address the requested service as prescribed. The ODG states follow up visits are based on ongoing medical need as dictated by response to prescribed treatment and continuation of complaints. The continued need cannot be determined for indefinite amount of follow up visits per the request and therefore the request is not medically necessary.