

Case Number:	CM15-0140231		
Date Assigned:	07/30/2015	Date of Injury:	05/28/2015
Decision Date:	09/22/2015	UR Denial Date:	07/15/2015
Priority:	Standard	Application Received:	07/20/2015

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 is a 53 year old male, who sustained an industrial injury on 5-28-15. He has reported initial complaints of neck, thoracic and back pain after falling from a vehicle. The diagnoses have included cervical sprain and strain, upper back sprain and strain, shoulder pain, contusion of chest wall, cervical radiculopathy, insomnia and left shoulder rotator cuff tear. Treatment to date has included medications, activity modifications, diagnostics, chiropractic, and other modalities. Currently, as per the physician first report progress note dated 7-9-15, the injured worker complains of neck and upper back pain that radiates down the left shoulder to the left forearm. He also reports numbness and tingling in the fingers of the left hand and rib cage pain. He complains of loss of sleep due to numbness and pain at night. The diagnostic testing that was performed included Magnetic Resonance Imaging (MRI) of the cervical spine and left shoulder. The objective findings-physical exam reveals that there is edema in the cervical and thoracic region. There is muscle spasm and tenderness in the cervical and thoracic areas. There is tenderness to palpation of the left shoulder. The cervical range of motion is limited due to pain at end range flexion, extension and left lateral flexion. There is positive cervical compression test, cervical distraction test, shoulder depression test, apley scratch test, apprehension test, ulnar nerve test and chest expansion test. There is previous chiropractic sessions noted in the records. Work status is modified on 7-9-15. The physician requested treatment included Chiropractic treatment for cervical and thoracic spine 3 times a week for 4 weeks.

IMR ISSUES, DECISIONS AND RATIONALES

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

Chiropractic treatment for cervical/thoracic spine 3 times a week for 4 weeks: Upheld

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

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 request is for 12 sessions. This does not meet criteria guidelines and thus is not medically necessary.