

Case Number:	CM15-0146979		
Date Assigned:	08/07/2015	Date of Injury:	02/22/2015
Decision Date:	09/09/2015	UR Denial Date:	07/15/2015
Priority:	Standard	Application Received:	07/28/2015

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: Chiropractor, Oriental 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 41-year-old male, who sustained an industrial injury on 2-22-15. Initial complaint was the result of an electrical shock causing the injured worker to fall from a ladder injuring the left upper extremity, chest and rib cage. The injured worker was diagnosed as having electric shock injury left upper extremity; cervical sprain-strain with left upper extremity radiculopathy; left chest rib contusion; left upper extremity numbness; left shoulder sprain-strain. Treatment to date has included physical therapy; medications. Currently, the PR-2 notes dated 6-11-15 indicated the injured worker complains of recurrent head pain involving the craniocervical region with radiation to the frontal area. The pain is described as pulsatile with intensity of 7 out of 10. The pain occurs daily and is associated with photophobia and phonophobia, occasional nausea but no vomiting. He reports neck pain and states nothing improves that pain. He reports radiation of numbness and tingling from the craniocervical region of the neck, shoulders and down the upper extremities. The symptoms with the neck are increased with prolonged sitting and keeping his neck in a fixed position. He wakes up during the night because of pain. He reports ongoing aching pain involving the left side of the chest wall with intensity of 6 out of 10 he reports that taking a deep breath worsens the discomfort. He reports continuous pain in the entire left upper extremity with intensity of 5 out of 10, which worsens with physical activities. He suffered a right facial paralysis in April 2015. He denies having any surgeries. He is currently working his regular duties. He reports that self-care activities are performed slowly and with discomfort. He reports the pain is currently severe but it is severe most of the time. Sometimes the pain interferes with his ability to travel and his ability to engage in social activities and with

his concentration and thinking. He cannot engage in recreational activities. His pain level averages 6 out of 10 and is 8 out of 10 at its worst. On physical examination, there is a 2+ tenderness involving the left craniocervical region reproducing his symptoms. He has a 2+ tenderness in the cervical paraspinal area and pain with extreme range of motion. There is tenderness along the upper trapezius. There is tenderness to pressure over the mid and lower left rib cage with tenderness to deep inspiratory movements. He has symmetrical deep tendon reflexes in the upper and lower extremities with intact vibration, light touch, pain and position. He has a normal stance and gait and toes stand and heel stands are normal. Tandem gait is normal as well as Romberg test negative. The provider is going to treat the injured worker conservatively until he receives diagnostic studies and records. The provider is requesting authorization of additional chiropractic therapy 12 visits.

IMR ISSUES, DECISIONS AND RATIONALES

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

Chiropractic Therapy 12 visits: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 58-59.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Manual Therapy and Manipulation Page(s): 58-59.

Decision rationale: Patient has had prior chiropractic treatments; however, clinical notes fail to document any functional improvement with prior care. Provider requested additional 12 chiropractic sessions which were non-certified by the utilization review. Medical reports reveal little evidence of significant changes or improvement in findings, revealing a patient who has not achieved significant objective functional improvement to warrant additional treatment. Per guidelines, 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. Requested visits exceed the quantity supported by cited guidelines. Per review of evidence and guidelines, 12 Chiropractic visits are not medically necessary.