

Case Number:	CM14-0141275		
Date Assigned:	09/10/2014	Date of Injury:	04/22/2014
Decision Date:	10/14/2014	UR Denial Date:	08/01/2014
Priority:	Standard	Application Received:	09/02/2014

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 Board Certified in Emergency Medicine and is licensed to practice in Texas. 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 injured worker is a 47-year-old female who reported an injury on 04/22/2014 due to a patient striking her twice, hitting her in the face and the eye. The injured worker complained of headaches and not being able to breathe through the right nostril and throbbing mid back pain. The injured worker had a diagnoses of dizziness, headache, cervical disc protrusion, cervical myospasm, cervical pain, cervical radiculopathy, cervical sprain/strain, lumbar muscle sprain, lumbar pain, lumbar sprain/strain, right shoulder impingement syndrome, right shoulder pain, right shoulder strain/sprain, and a fractured nose. The objective findings dated 08/19/2014 to the cervical spine revealed flexion of 50/50 degrees, extension 60/60 degrees, left lateral bending 40/45 degrees, right lateral bending 40/45 degrees, tenderness to palpation at the cervical paravertebral muscles with muscle spasms to the cervical vertebrae muscles. Lumbar examination revealed a tenderness to palpation over the paravertebral muscles with flexion of 50/60 degrees and extension 25/25 degrees. The Kemp's test was positive bilaterally, straight leg raise was positive bilaterally. No medications were noted, no VAS was noted. The prior treatment plan was chiropractic therapy and physical therapy. The current treatment plan is for chiropractic therapy and physical therapy. The Request for Authorization dated 09/10/2014 was submitted with documentation.

IMR ISSUES, DECISIONS AND RATIONALES

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

Chiropractic one to two times per week for four weeks: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Page(s): 265, 339, 369, 106, 111, 115.,Chronic Pain Treatment Guidelines Page of 127 58.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Page(s): 58.

Decision rationale: The request for Chiropractic one to two times per week for four weeks is not medically necessary. The California MTUS Guidelines state that chiropractic care for chronic pain if caused by musculoskeletal conditions is recommended. The intended goal of effect of manual medicine is the achievement of positive symptomatic or objective measurable gains and functional improvement that facilitates progress in the patients therapeutic exercise program and return to productive activities. The guidelines recommend a trial of 6 visits over 2 weeks and with evidence of objective functional improvement a total of 18 visits over 6 to 8 weeks. The clinical notes indicated that the injured worker had received at least 5 visits of chiropractic therapy; however, there is lack of documentation indicating that the injured worker had significant objective functional improvement with the prior therapy. As such, the request is not medically necessary.

Physical Therapy (PT) one to two times per week for four weeks: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page of 127 58Page 22.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Page(s): 98.

Decision rationale: The request for Physical Therapy (PT) one to two times per week for four weeks is not medically necessary. The California MTUS state that active therapy is based on the philosophy that therapeutic exercise and/or activity are beneficial for restoring flexibility, strength, endurance, function, range of motion, and to alleviate discomfort. Active therapy requires an internal effort by the individual to complete a specific exercise or task. Injured workers are instructed and expected to continue active therapies at home as an extension of the treatment process in order to maintain improvement levels. The clinical notes indicate that the injured worker had received 17 visits of physical therapy. The guidelines indicate up to 10 visits of physical therapy. The request is for up to 8 more visits, exceeding the recommended guidelines. The clinical notes did not warrant any special circumstances for additional therapy. As such, the request is not medically necessary.