

Case Number:	CM14-0143791		
Date Assigned:	09/12/2014	Date of Injury:	09/22/2011
Decision Date:	10/10/2014	UR Denial Date:	08/06/2014
Priority:	Standard	Application Received:	09/05/2014

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 Chiropractic and Acupuncture and is licensed to practice in California. 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 49 year old female who reported neck, and bilateral upper extremity pain from injury sustained on 09/11/11. Mechanism of injury was not documented in the provided medical records. MRI of the cervical spine dated 04/04/13 revealed slight reversal of cervical lordosis. NCV of the upper extremity dated 01/15/13 revealed mild compression of right median nerve with left mild compression of median nerve as well as right mild compression of the ulnar nerve. Patient is diagnosed with chronic bilateral elbow tendonitis, right greater than left; chronic ulnar nerve impingement, right greater than left; mild carpal tunnel syndrome, right greater than left; status post carpal tunnel release on the right and cervical spine sprain/strain. Per medical notes dated 07/23/14, patient complains of persistent neck pain rated at 7/10. She states that it is the same id not worsening. She does get stiff every few days and it is hard to function and drive. She states it radiates to her bilateral upper extremity. Pain is made better with rest and medication from 7/10 to 4/10. Provider is requesting chiropractic X8. Per medical notes dated 08/15/14, patient complains of persistent pain affecting bilateral extremity. Examination revealed to palpation of the cervical spine paraspinal muscles and trapezius. There is no evidence that this patient exhibits significant functional loss and is unable to perform an independent, self-directed, home exercise program, rather than chiropractic intervention.

IMR ISSUES, DECISIONS AND RATIONALES

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

8 Chiropractic treatment with massage for the cervical spine two times a week for four weeks: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ACOEM Cervical and Thoracic Spine; Table 2, Summary of Recommendations, Cervical and Thoracic Spine Disorders. Official Disability Guidelines; Work Loss Data Institute, LLC; Corpus Christi, TX; www.odg-twc.com; Section: Neck and Upper Back

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

Decision rationale: Per MTUS- Chronic Pain medical treatment guideline - Manual therapy and manipulation Page 58-59. "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 objectively measureable gain in functional improvement that facilitate progression in the patient's therapeutic exercise program and return to productive activities". 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. Reoccurrences/ flare-ups- need to re-evaluate treatment success, if RTW achieved then 1-2 visits every 4-6 months. Treatment parameters from state guidelines. A) Time of procedure effect: 4-6 treatments. B) Frequency 1-2 times per week the first 2 weeks as indicated by the severity of the condition. Treatment may continue at 1 treatment per week for the next 6 weeks. C) Maximum duration: 8 weeks. At 8 weeks patient should be re-evaluated. Care beyond 8 weeks may be indicated for certain chronic pain patients in whom manipulation has been helpful in improving function, decreasing pain and improving quality of life. Treatment beyond 4-6 visits should be documented with objective improvement in function". Patient has not had prior chiropractic treatments. Per guidelines 4-6 treatments are supported for functional improvement. Requested visits exceed the quantity supported of initial trial of Chiropractic by cited guidelines. There is no evidence that this patient exhibits significant functional loss and is unable to perform an independent, self-directed, home exercise program, rather than skilled chiropractic intervention. Per review of evidence and guidelines, 8 Chiropractic visits are not medically necessary.