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| Case Number: | CM15-0019671 | | |
| Date Assigned: | 02/09/2015 | Date of Injury: | 06/13/2005 |
| Decision Date: | 03/25/2015 | UR Denial Date: | 12/29/2014 |
| Priority: | Standard | Application Received: | 02/02/2015 |

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 65 year old female, who sustained an industrial injury on 06/13/2005. Medical records provided by the treating physician did not indicate the injured worker's mechanism of injury. Diagnoses include cervical spine disc bulge, thoracic spine strain, lumbar spine strain, right shoulder strain, left shoulder strain, right wrist/hand strain, and left wrist/hand strain. Treatment to date has included medication regimen, chiropractic therapy, use of H-Wave device, physical therapy, and use of transcutaneous electrical nerve stimulation unit. In a progress note dated 09/09/2014 the treating provider reports complaints of pain to the neck, upper back, lower back, right and left shoulder/arm, and right and left wrist/hand. On 12/09/2014, the treating physician requested chiropractic therapy to the cervical, thoracic, and lumbar spine but did not indicate the reason for the requested treatment. On 12/29/2014 Utilization Review non-certified the requested treatment of chiropractic one times six for the cervical/ thoracic/ lumbar spine, noting the California Medical Treatment Utilization Schedule and American College of Occupational and Environmental Medicine Guidelines.

IMR ISSUES, DECISIONS AND RATIONALES

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

Chiropractic 1 times 6 for the cervical/thoracic/lumbar spine: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM, Chronic Pain Treatment Guidelines Manual therapy & manipulation. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG)

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 6 chiropractic sessions which were not medically necessary by the utilization review. Medical records 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. Per review of evidence and guidelines, 1X6 Chiropractic visits are not medically necessary.