

Case Number:	CM15-0078761		
Date Assigned:	04/29/2015	Date of Injury:	11/22/1999
Decision Date:	05/29/2015	UR Denial Date:	04/07/2015
Priority:	Standard	Application Received:	04/24/2015

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: Physical Medicine & Rehabilitation, Pain Management

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 75 year old female, who sustained an industrial injury on 11/22/1999. The medical records submitted for this review included daily treatment notes from chiropractic therapy sessions provided. There was no documentation submitted for this review that included treatment diagnoses, certified plan of care, or prior treatments to date. Currently, she complained of an acute flare up of neck pain and headaches due to normal daily activities and received several chiropractic therapy treatments. On 2/25/15, the daily treatment note documented muscle tenderness, triggers point, and decreased cervical range of motion. Pain was rated 4/10 VAS. The treatment included spinal manipulation to the cervicothoracic region and acupressure point to the sub occiput. There was ultrasound and muscle stimulation administered. The daily note documented 75% improvement in neck pain and headache relief. The treatment goal included "relief of flare ups, reduction of inflammation and pain."

IMR ISSUES, DECISIONS AND RATIONALES

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

Retrospective request for 1 Spinal manipulation between 03/13/2015: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Manual Therapy & Manipulation. Decision based on Non-MTUS Citation Official Disability Guidelines Chiropractic Guidelines.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines x 8 C.C.R. 9792.20 - 9792.26 MTUS (Effective July 18, 2009) Page(s): 58-60 of 127.

Decision rationale: Regarding the request for additional chiropractic care, Chronic Pain Medical Treatment Guidelines support the use of chiropractic care for the treatment of chronic pain caused by musculoskeletal conditions. Guidelines go on to recommend a trial of up to 6 visits over 2 weeks. With evidence of objective functional improvement, a total of up to 18 visits over 6 to 8 weeks may be supported. In the case of recurrences/flare-ups, the CA MTUS cites a need to re-evaluate treatment success, if RTW achieved then 1-2 visits every 4-6 months. Within the documentation available for review, the patient is apparently receiving frequent treatment for flare-ups approximately every month with no demonstrable objective evidence of functional improvement or a rationale for treatment exceeding the recommendations of the CA MTUS rather than utilization of an independent home exercise program. In light of the above issues, the currently requested chiropractic care is not medically necessary.

Retrospective request for 1 physiotherapy ultrasound/sinewave between 03/13/2015 and 03/13/2015: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines Low Back & Thoracic (Acute & Chronic) Ultrasound Therapeutic.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 173.

Decision rationale: Regarding the request for physiotherapy ultrasound/sine wave sessions, CA MTUS and ACOEM state that there is no high-grade scientific evidence to support the effectiveness or ineffectiveness of passive physical modalities such as traction, heat/cold applications, massage, diathermy, cutaneous laser treatment, ultrasound, transcutaneous electrical neurostimulation (TENS) units, and biofeedback. These palliative tools may be used on a trial basis but should be monitored closely. Emphasis should focus on functional restoration and return of patients to activities of normal daily living. Within the documentation available for review, there is no evidence of demonstrable objective functional improvement from prior use of these modalities and a clear rationale for their use despite the recommendations of the guidelines. In light of the above issues, the currently requested physiotherapy ultrasound/sine wave sessions are not medically necessary.