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| <b>Case Number:</b>   | CM13-0008917 |                              |            |
| <b>Date Assigned:</b> | 04/23/2014   | <b>Date of Injury:</b>       | 07/28/2011 |
| <b>Decision Date:</b> | 06/10/2014   | <b>UR Denial Date:</b>       | 07/26/2013 |
| <b>Priority:</b>      | Standard     | <b>Application Received:</b> | 08/08/2013 |

### 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 Physical Medicine and Rehabilitation, has a subspecialty in Neuromuscular Medicine and is licensed to practice in Maryland. 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 patient is a 43 year old female who has a work injury dated 7/28/11. The diagnoses include status post right shoulder arthroscopic subacromial decompression on 03/05/2012, status post artificial disk replacement at C5-6, 11/7/13, lumbar radiculopathy, multilevel disc herniations of lumbar spine. There is a request for chiropractic treatment for the neck, right shoulder and back, 6 sessions as well as a general orthopedic follow up evaluation. There is documentation that on a May 21, 2013 progress report the patient reported that chiropractic manipulation had increased her symptoms and she wanted no further chiropractic treatment. She stated that she continued exercising at home. The patient was considered temporarily partially disabled with a temporary restriction of no use of the right upper extremity. A 1/14/14 primary physician treating progress report states that the patient is about two months status post artificial disc replacement at C5-6. She rates her neck pain that she rates at 5/10 on pain scale and feels approximately 50% relief since her surgery on 11/7/2013. She reports persistent spasms in her neck that she feels an aching pain on her cervical spine. She currently rates her lower back pain as a 6/10 on the pain scale. She describes her back pain as a constant stabbing. She has numbness in her right hand, which is constant but improved compared to before surgery. She reports numbness and tingling in her right leg, which is intermittent. She started post operative physiotherapy for her neck last week and has had two visits so far. She continues with her psychiatrist. She says she has not taken Percocet for about two weeks because she is trying to minimize her medication use. She says she is taking Zanaflex day for spasms, and Ketoprofen. She says the medications do help decrease her pain and allows her to increase her sleep and increase her activity level by approximately 60%. On examination the range of motion of cervical and lumbar spines are decreased in all planes and limited by pain. Cervical surgery site is clean, dry and intact. Decrease sensation C5,

C6 and C8 dermatomes on right. Decrease sensation L4, L5 and S1 dermatomes on right. Deltoid biceps, wrist extensors, wrist flexors, internal rotators and external rotators 5-/5 on right. Tibialis anterior, EHL, inversion, eversion, and plantar flexors are 4+/5 on right and 5-/5 on left. The treatment plan included continuing Zanaflex, Percocet and Senna. There is a 4/16/14 Agreed Medical Evaluation that states that the treatment provided by the patient's physician and associates has also included prolonged physical therapy, chiropractic manipulation and acupuncture. The document states that although the patient never reported that acupuncture aggravated her symptoms, the records clearly show she has repeatedly stated physical therapy, exercise and chiropractic manipulation have caused all her problems to worsen. The records also reflect that the provider and his associates continued to order such treatment, despite the overwhelming evidence that it was not only manifestly ineffective, but actually aggravating symptoms rather than curing or relieving them, according to the patient. Per the 4/16/14 AME brief course of physical therapy would be indicated for the cervical spine post-operatively, with a rapid transition to an home exercise program. Thereafter, no further office-based, supervised treatment would be indicated for the cervical spine, right shoulder, right elbow, thoracic spine, lumbosacral spine, bilateral lower extremities or left upper extremity, inclusive of the left shoulder. This would be inclusive of all passive modalities of physical therapy, supervised exercise, chiropractic manipulation, massage, acupuncture or electrical stimulation. Additionally the AME states that no further surgical treatment are indicated for the right shoulder. Absent clear and compelling indications for surgery on an MRI study of the lumbar spine and validation by means of a second opinion consultation with a fellowship-trained spine surgeon, no surgery is indicated for the lumbar spine.

### **IMR ISSUES, DECISIONS AND RATIONALES**

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

#### **CHIROPRACTIC TREATMENT FOR NECK, RIGHT SHOULDER, AND BACK, 6 SESSIONS: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Chiropractic Treatment Section, Manual Therapy & Manipulation Section, Page(s): 30, 50.

**Decision rationale:** Chiropractic treatment for the neck, right shoulder and back, 6 sessions is not medically necessary per the Chronic Pain Medical Treatment MTUS guidelines. Per guidelines there should be a trial of chiropractic visits with 6 visits over 2 weeks, with evidence of objective functional improvement. The guidelines state that there should be positive symptomatic or objective measurable gains in functional improvement. The documentation submitted reveals that the patient has had a numerous chiropractic sessions without significant improvement in function or pain. A 4/16/14 AME notes that patient has not received any benefit from chiropractic care and the patient should not continue to receive further chiropractic therapy. The request for continued chiropractic care is not medically appropriate or medically necessary.

**GENERAL ORTHOPEDIC FOLLOW UP EVALUATION:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 209-210, Chronic Pain Treatment Guidelines Functional Restoration Section Page(s): 8.

**Decision rationale:** The MTUS Chronic Pain Medical Treatment Guidelines state that whether the treatment is provided by an individual provider, a multidisciplinary group of providers, or tightly integrated interdisciplinary pain program, it is important to design a treatment plan that explains the purpose of each component of the treatment. The most recent AME dated 4/16/14 reveals that the patient has no surgical indications at this time. The ACOEM MTUS guidelines state that if there is a surgical lesion or red flag a referral is appropriate. Without a surgical lesion or red flag on examination and the fact that the patient is in pain management already, the request for a general orthopedic follow up evaluation is not medically necessary.