

<b>Case Number:</b>	CM14-0012644		
<b>Date Assigned:</b>	02/21/2014	<b>Date of Injury:</b>	05/09/2013
<b>Decision Date:</b>	06/26/2014	<b>UR Denial Date:</b>	01/02/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	01/31/2014

### 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 Physical Medicine and Rehabilitation, has a subspecialty in Pain Medicine 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 patient is a 56 year old female who was injured on 05/09/2013 while packing, lifting and shifting 40 pound boxes which caused serious pain in the head, neck, upper back, left shoulder/arm, low back and legs. Prior treatment history has included physical therapy and home exercises to do at home on 06/29/2013. She has used a TENS unit with 40-60% relief, trigger point injections with 40-60% relief and medication which include Flexeril, Valium and Ativan with 40-60% relief. The patient underwent cervical spine surgery in August of 2005 and rotator cuff repair. Diagnostic studies were not submitted for review. PR-2 dated 12/19/2013 has a request for chiropractic adjustments, myofascial release, core stabilizing, electrical stimulation and stim phototherapy. Progress report dated 01/15/2014 documented the patient with a myriad of complaints. Her neck pain she rates a 3/10 on the pain scale. Her low back pain she rates a 4/10 on a pain scale. She complains of headaches, weakness in her neck and arms along with tingling in her feet. She also has mid back pain and popping in her low back as well as pain in the left shoulder. There is also pain down her left arm. Objective findings on examination show improvement in her neck movements. Flexion and extension are both 25 degrees, left rotation is 50 degrees, right rotation 55 degrees, left lateral flexion is 40 degrees and right lateral flexion is 40 degrees. There is still pain throughout her upper thoracic and low neck, especially with flexion. Neck pain that is achy in nature is felt with extension and both rotational movements. Movement of her low back also shows improvement with flexion now 60 degrees, extension 15 degrees, left and right rotation 20 degrees and the lateral flexions are 30 degrees each. Pain in the neck is felt with flexion of low back, there is now low back pain with this movement. Low back pain is felt with extension. Low back pain is felt with both lateral flexion positions. Contralateral pulling and ipsilateral pain is felt in lateral flexion positions. There is no significant pain with rotation. Sensory testing with the Wartenberg pinwheel also shows

improvement. She has reduced sensations in her left hand and the left upper thigh and left lateral aspect of her lower leg. More than mild tenderness is felt throughout the low neck, left upper shoulder and lumbosacral areas. Foraminal compression test shows positive for localized low neck/upper back pain with all movements. Shoulder depression test is positive bilaterally but more so on the left than the right. Soto Hall tests creates low neck and upper back pain. Kemp sign creates low back pain with the right and its negative on the left. Straight leg raise test at 60 degrees on the right and creates pulling in the leg. The left straight leg raise is measured at 65 degrees and creating low back pain as well. Yeaoman's test on the left creates low back pain. Patient demonstrates weakness in her hip flexors bilaterally. Her range of motion in the shoulder is full, Diagnoses: 1. Cervical radiculitis 2. Cervical spondylosis without myelopathy 3. Lumbar radiculitis 4. Lumbar stenosis 5. Lumbar disc pathology Plan: I am asking more 10 conservative chiropractic treatments including therapy to help this patient improve. Please consider approval for this care. UR report dated 01/02/2014 partially certified chiropractic treatment to 3-4 spinal regions for 6 visits and the other 6 visits requested are not certified. Objective findings note reduced neck and neck range of motion, positive but nonspecific orthopedic testing and nonspecific palpable tenderness and muscle spasms. Prior records do not suggest conservative treatment has included chiropractic treatment. The request for myofascial release, massage therapy, hot/cold packs and electrical stimulation were certified.

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

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

#### **CHIROPRACTIC TREATMENT TO 3-4 SPINAL REGIONS TWICE A WEEK FOR 4-6 WEEKS QUANTITY #12: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Manual Therapy And Manipulation Page(s): 58-60.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Manual therapy & manipulation Page(s): 58-60.

**Decision rationale:** According to the CA MTUS guidelines, chiropractic manipulation therapy/manipulation is 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 objective measurable gains in functional improvement that facilitate progression in the patient's therapeutic exercise program and return to productive activities. Treatment beyond 4-6 visits should be documented with objective improvement in function. Palliative care should be reevaluated and documented at each treatment session. The guidelines state if chiropractic treatment is going to be effective, there should be some outward sign of subjective or objective improvement within the first 6 visits. According to the medical records, the patient initiated chiropractic treatment in December 19, 2013. She was authorized 6 sessions to include chiropractic adjustment to 3-4 regions, along with myofascial release, massage, electrical stimulation, and hot/cold packs. According to a previous treating physician's 10/14/2013 and 11/25/2013 medical reports, the patient reported 3/10 and 4/10 pain levels, respectively. The 1/15/14 PR-2 of [REDACTED] DC, indicates the patient describes a myriad of complaints and reports 3/10 neck pain and 4/10 low back pain. She is

pending an orthopedic evaluation for the left shoulder, and is very interested in further surgery to the left shoulder and neck. She remains on TTD status. Examination on 1/15/2014 documents limited ranges of motion, pain with motion testing, tenderness, and positive/pain with various orthopedic test maneuvers. The medical records do not reveal the patient's pain level and medication use have decreased, or function improved. The medical records do not reflect that this patient has obtained any clinically significant benefit with the initial course of 6 chiropractic and adjunctive therapies. Given the lack of notable benefit with rendered care, the medical records do not establish additional treatment is indicated as medically necessary. Therefore, the request is not medically necessary.

**MYOFASCIAL RELEASE QUANTITY #12: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Manual Therapy And Manipulation Page(s): 58-60.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Massage Therapy Page(s): 60.

**Decision rationale:** According to the CA MTUS guidelines, massage therapy is recommended as an option, this treatment should be an adjunct to other recommended treatment (e.g. exercise), and it should be limited to 4-6 visits in most cases. The guidelines state massage is beneficial in attenuating diffuse musculoskeletal symptoms, but beneficial effects were registered only during treatment. Massage is a passive intervention and treatment dependence should be avoided. According to the medical records, the patient's recent course of care has included 6 sessions of myofascial release provided in conjunction with chiropractic care and other passive palliative therapies. The patient has already received the recommended number of sessions. In addition, objective improvement has not been demonstrated in this case, to warrant consideration for further treatment. Therefore, based on guidelines and a review of the evidence, the request is not medically necessary.

**MASSAGE THERAPY QUANTITY #12: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Manual Therapy And Manipulation Page(s): 58-60.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Massage Therapy Page(s): 60.

**Decision rationale:** According to the CA MTUS guidelines, massage therapy is recommended as an option, this treatment should be an adjunct to other recommended treatment (e.g. exercise), and it should be limited to 4-6 visits in most cases. The guidelines state massage is beneficial in attenuating diffuse musculoskeletal symptoms, but beneficial effects were registered only during treatment. Massage is a passive intervention and treatment dependence should be avoided. According to the medical records, the patient's recent course of care has included 6 sessions of massage therapy provided in conjunction with chiropractic care and other passive palliative therapies. The patient has already received the recommended number of visits. In addition, objective

improvement has not been demonstrated in this case, to warrant consideration for further treatment. Therefore, the request is not medically necessary.

**HOT/COLD PACKS QUANTITY #12: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Manual Therapy and Manipulation Page(s): 58-60.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 3 Initial Approaches to Treatment Page(s): 48, 173-174.

**Decision rationale:** The ACOEM guidelines suggest, "During the acute to subacute phases for a period of 2 weeks or less, physicians can use passive modalities such as application of heat and cold for temporary amelioration of symptoms and to facilitate mobilization and graded exercise. They are most effective when the patient uses them at home several times a day." The guidelines also state, there is no high-grade scientific evidence to support the effectiveness or ineffectiveness of passive physical modalities such as heat/cold applications, massage, and transcutaneous electrical neurostimulation (TENS) units. 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. The patient was provided 6 sessions of chiropractic care, which included hot/cold pack application, and other palliative interventions. The medical records do not establish the treatment led to objective functional improvement with care. Given the lack of notable benefit with rendered care, the medical records do not establish additional treatment is indicated. Therefore, the request is not medically necessary.

**ELECTRICAL STIMULATION QUANTITY #12: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Manual Therapy and Manipulation Page(s): 58-60.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 300, Chronic Pain Treatment Guidelines Manual therapy & manipulation Page(s): 58-59.

**Decision rationale:** According to the guidelines, "Insufficient evidence exists to determine the effectiveness of sympathetic therapy, a noninvasive treatment involving electrical stimulation, also known as interferential therapy." detailed above, the patient has completed 6 authorized sessions of chiropractic care with adjunctive therapies including electrical stimulation. The medical records do not establish this patient obtained clinically significant benefit with rendered care. Consequently, additional treatment of this nature is not medically indicated. The medical necessity has not been established. Therefore, the request is not medically necessary.