

Case Number:	CM14-0018518		
Date Assigned:	04/18/2014	Date of Injury:	01/12/2012
Decision Date:	07/02/2014	UR Denial Date:	01/13/2014
Priority:	Standard	Application Received:	02/13/2014

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 Emergency Medicine, and is licensed to practice in New York. 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 54- year-old male who was injured on January 12, 2012. The patient continued to experience pain in his neck and right shoulder. Physical examination was notable for decreased range of motion of the neck, positive cervical compression test and no motor deficits. X-rays of the cervical spine dated February 25, 2011 showed cervical spondylosis. Diagnoses included cervical strain, right shoulder pain/ post-operative right shoulder arthroscopy, right elbow pain, and right cervical radical symptoms. Treatment included physical therapy and chiropractic therapy, which was documented as beneficial in the past. Other therapies included acupuncture. Physical therapy 6 visits and chiropractic therapy 6 visits were requested on June 4, 2013, June 18, 2013, and July 15, 2013. The number of visits received is unclear. Requests for authorization for physical therapy 8 sessions and chiropractic therapy 6 sessions were submitted for consideration.

IMR ISSUES, DECISIONS AND RATIONALES

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

PHYSICAL THERAPY, QTY: 8: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines PHYSICAL MEDICINE.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines PAIN INTERVENTIONS AND GUIDELINES Page(s): 98-99.

Decision rationale: Chronic Pain Medical Treatment Guidelines 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, TENS units, ultrasound, laser treatment, or biofeedback. They can provide short-term relief during the early phases of treatment. Active treatment is associated with better outcomes and can be managed as a home exercise program with supervision. ODG states that physical therapy is more effective in short-term follow up. Patients should be formally assessed after a "six-visit clinical trial" to see if the patient is moving in a positive direction, no direction, or a negative direction (prior to continuing with the physical therapy). When treatment duration and/or number of visits exceed the guideline, exceptional factors should be noted. In this case the number of sessions requested surpasses the recommended six-visit clinical trial. In addition the number of prior visits received and documentation of objective evidence of functional improvement is not documented. Medical necessity has not been established. The request is not medically necessary.

CHIROPRACTIC TREATMENTS, QTY 6: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines MANUAL THERAPY & MANIPULATION.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines PAIN INTERVENTIONS AND GUIDELINES Page(s): 58-59.

Decision rationale: Chiropractic treatment is a type of manual therapy and evaluation. It is recommended for chronic pain if caused by musculoskeletal conditions. The intended goal or effect of manual therapy 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. Manipulation is manual therapy that moves a joint beyond the physiologic range-of-motion but not beyond the anatomic range-of-motion. If chiropractic treatment is going to be effective, there should be some outward sign of subjective or objective improvement within the first 6 visits. Manipulation of the cervical spine is recommended up to six visits over 2-3 weeks. There is limited evidence to specifically support the utilization of manipulative procedures of the shoulder. In this case the patient had received prior chiropractic treatment. The number of prior visits received and documentation of objective evidence of functional improvement is not documented. Medical necessity has not been established. The request is not medically necessary.