

Case Number:	CM14-0111052		
Date Assigned:	08/01/2014	Date of Injury:	09/20/2002
Decision Date:	09/09/2014	UR Denial Date:	07/07/2014
Priority:	Standard	Application Received:	07/16/2014

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 licensed Chiropractic 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 60-year-old female born on 07/15/1954. The date of injury is noted as occurring on 09/20/2002, but no history of injury was provided for this review. The patient presented for chiropractic care on 11/27/2013. She reported her lower back had been doing well since the last visit on 11/06/2013. The 11/27/2013 record reports subjectives of 9/10 neck symptoms, 5/10 headache, 6/10 left shoulder symptoms, 8/10 upper back symptoms, 7/10 right shoulder symptoms, 2/10 low back symptoms, 2/10 mid back symptoms, and bilateral knee symptoms. Treatment procedures included spinal and extra spinal manipulation, diathermy, and myofascial release. The chart note 01/06/2014 reports subjectives of 9/10 low back symptoms, 8/10 mid back symptoms, and for/10 neck symptoms. Treatment procedures included spinal and extra spinal manipulation, diathermy, neuromuscular reeducation, and electrical stimulation. The chiropractor requested authorization for the treatment on 01/06/2014. On 01/22/2014, the patient reported she needed a treatment for her lower back. Subjectives were noted as 6/10 low back symptoms, 4/10 mid back symptoms, 2/10 neck symptoms, 2/10 left shoulder symptoms, 3/10 right shoulder symptoms, 2/10 upper back symptoms, and bilateral knee symptoms. Treatment procedures included spinal and extra spinal manipulation, electrical stimulation, massage, and traction. On 02/19/2014, the patient reported she needed a treatment for lower back. Subjectives were noted as 9/10 low back symptoms, 8/10 mid back symptoms, or/10 neck symptoms, 2/10 headaches, 2/10 left shoulder symptoms, 2/10 upper back symptoms, 2/10 right shoulder symptoms, bilateral knee symptoms, and for/10 right foot symptoms. Treatment procedures included spinal and extra spinal manipulation, electrical stimulation, and massage. On 03/24/2014, the subjectives were noted as 8/10 neck symptoms, 8/10 right shoulder symptoms, 8/10 headaches, 2/10 low back symptoms, 2/10 mid back symptoms, 2/10 left shoulder symptoms, and bilateral knee symptoms. Treatment included spinal and extra spinal

manipulation, massage, electrical stimulation, and traction. There is a request for 1 chiropractic/physiotherapy treatment for a reported flare-up.

IMR ISSUES, DECISIONS AND RATIONALES

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

Retrospective (unknown) Chiropractic treatment and physiotherapy one treatment for acute flare up, back and hips: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Manual therapy & manipulation Page(s): 58.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Manual Therapy and Manipulation Page(s): 58-60. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Neck & Upper Back (Acute & Chronic), Procedure Summary - Manipulation/ODG Chiropractic Guidelines, Updated 08/04/2014.

Decision rationale: The request for 1 chiropractic/physiotherapy treatment for a reported flare-up is not supported to be medically necessary. MTUS and ODG do not support medical necessity for additional chiropractic/physiotherapy visits. Regarding the request for additional chiropractic/manual therapy & manipulation: MTUS (Chronic Pain Medical Treatment Guidelines, Manual Therapy and Manipulation) supports a trial of up to 6 visits of manual therapy and manipulation in the treatment of chronic low back pain complaints but reports no recommendations for or against manual therapy and manipulation in the treatment of cervical and thoracic conditions; therefore, both MTUS and ODG will be referenced. MTUS (Medical Treatment Utilization Guidelines, Manual Therapy and Manipulation) supports a trial of up to 6 visits of manual therapy and manipulation in the treatment of chronic low back pain complaints if caused by musculoskeletal conditions. With evidence of objective functional improvement with care during the 6-visit treatment trial, a total of up to 18 visits over 6-8 weeks may be considered. Elective/maintenance care is not medically necessary. Relative to recurrences/flare-ups, there is the need to evaluate prior treatment success, if RTW (return to work) then 1-2 visits every 4-6 months. Because MTUS reports no recommendations for or against manual therapy and manipulation in the treatment of cervical and thoracic conditions, ODG is the reference source for such. ODG Treatment, Neck and Upper Back (Acute & Chronic), Procedure Summary - Manipulation/ODG Chiropractic Guidelines: In the treatment of neck pain and cervical strain, ODG supports a 6-visit trial of care over 2-3 weeks, with consideration for additional treatment sessions (a total of up to 18 visits over 6-8 weeks, avoid chronicity) based upon evidence of objective functional improvement with care rendered during the treatment trial. The submitted documentation indicates the patient treated with ongoing chiropractic care on 11/27/2013, 01/06/2014, 01/22/2014, 02/19/2014, and 03/24/2014. There is no record of prior treatment dates or patient response to care. There is no evidence of measured objective functional improvement with chiropractic care rendered during a 6-visit treatment trial, no evidence of lasting improvement with chiropractic care, no measured evidence of an acute flare-up, no evidence of a new condition, and elective/maintenance care is not supported. If the patient has returned to work then 1-2 visits every 4-6 months can be considered, but in this case the documentation indicates since 11/27/2013 the patient had typically been treating on a monthly basis. The request for

additional chiropractic treatment visits exceeds MTUS and ODG recommendations and is not supported to be medically necessary. Regarding the request for additional physiotherapy: MTUS (Chronic Pain Medical Treatment Guidelines, Physical Medicine/Physical Therapy) describes passive therapy as treatment modalities that do not require energy expenditure on the part of the patient. These modalities can provide short-term relief during the early phases of pain treatment and are directed at controlling symptoms such as pain, inflammation and swelling and to improve the rate of healing soft tissue injuries. Passive modalities can be used sparingly with active therapies to help control swelling, pain and inflammation during the rehabilitation process. This patient's injury occurred on 09/20/2002 and she is no longer considered in the early phases of care during which passive modalities may be indicated. The patient has already treated in excess of guidelines recommendations without evidence of efficacy with care rendered, without evidence of acute exacerbation, and without evidence of a new condition; therefore, the request for an additional physiotherapy session is not supported to be medically necessary.