

Case Number:	CM14-0021807		
Date Assigned:	05/07/2014	Date of Injury:	05/29/2012
Decision Date:	07/09/2014	UR Denial Date:	02/06/2014
Priority:	Standard	Application Received:	02/21/2014

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 Chiropractic and Acupuncture 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 injured worker is a 51 year old male who reported bilateral upper extremity; bilateral knee; bilateral shoulder; bilateral hands; neck; mid back and low back pain from injury sustained on 5/29/12. Patient sustained an injury while lifting scenery weighing 800 pounds. Patient is diagnosed with status post cervical spine surgery; right cervical radiculopathy; bilateral shoulder rotator cuff tear; bilateral facet arthropathy; bilateral knee arthralgia; multilevel bilateral cervical neural foraminal narrowing; cervical canal stenosis and multilevel cervical degenerative disc disease. Per utilization review, patient has been treated with laminoplasty; physical therapy; epidural injection and chiropractic. Per primary treating physician's progress notes dated 12/11/13, patient following up for neck and back pain. He is having shoulder surgery tomorrow. Patient indicates his pain in the back and neck is rated at 8/10. He is having radiation with numbness and tingling down bilateral arms. He states that he believes there is loosening of hardware in his neck. He states that his pain is incapacitating. "We are requesting 8 sessions of chiropractic rehabilitative therapy without forceful manipulation of patient's cervical and lumbar spine". There is no assessment in the provided medical records of functional efficacy with prior chiropractic visits. Medical reports reveal little evidence of significant changes or improvement in findings, revealing a patient who has not achieved significant objective functional improvement to warrant additional improvement. Additionally requested visits exceed the quantity of visits supported by cited guidelines.

IMR ISSUES, DECISIONS AND RATIONALES

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

CHIROPRACTIC TREATMENT: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Guidelines.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 173, Chronic Pain Treatment Guidelines Manual Therapy and Manipulation Page(s): 58-59.

Decision rationale: Per MTUS- Chronic Pain medical treatment guideline - Manual therapy and manipulation Page 58-59. "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 objectively measureable gain in functional improvement that facilitates progression in the patient's therapeutic exercise program and return to productive activities". Low Back: Recommended as an option. Therapeutic care- trial of 6 visits over 2 weeks, with evidence of objective functional improvement, total of up to 18 visits over 6-8 weeks. Elective/ maintenance care- not medically necessary. Reoccurrences/ flare-ups- need to re-evaluate treatment success, if RTW achieved then 1-2 visits every 4-6 months. Treatment parameters from state guidelines. A) Time of procedure effect: 4-6 treatments. B) Frequency 1-2 times per week the first 2 weeks as indicated by the severity of the condition. Treatment may continue at 1 treatment per week for the next 6 weeks. C) Maximum duration: 8 weeks. At 8 weeks patient should be re-evaluated. Care beyond 8 weeks may be indicated for certain chronic pain patients in whom manipulation has been helpful in improving function, decreasing pain and improving quality of life. Treatment beyond 4-6 visits should be documented with objective improvement in function". Patient has had prior chiropractic treatment; however, clinical notes fail to document any functional improvement with prior care. Per guidelines, functional improvement means either a clinically significant improvement in activities of daily living or a reduction in work restrictions as measured during the history and physical exam. Primary treating physician is requesting "8 sessions of chiropractic rehabilitative therapy without forceful manipulation of the patient's cervical and lumbar spine". Per ACOEM guidelines on page 173, there is no high-grade scientific evidence to support the effectiveness of passive physical modalities; emphasis should focus on functional restoration. Additionally requested visits exceed the quantity of visits supported by cited guidelines. Therefore, the request for chiropractic treatment is not medically necessary and appropriate.