

Case Number:	CM14-0029709		
Date Assigned:	07/11/2014	Date of Injury:	06/17/2011
Decision Date:	08/08/2014	UR Denial Date:	02/12/2014
Priority:	Standard	Application Received:	03/07/2014

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 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 62-year-old female born on [REDACTED]. During the course of her employment as a Home Care Provider, she developed pain and discomfort in her neck, entire back, left shoulder, hands, elbows, and knees with the injury date noted as 6/17/11. She has treated with medical care and been provided an unknown amount of physical therapy and chiropractic care. The primary treating physician's permanent and stationary report of 5/6/14 noted that the patient began chiropractic care on both 9/4/11 and 10/12/12; was receiving chiropractic care as of 10/30/12, 11/12/13, and 12/10/13; and requested more chiropractic care on 1/22/13, 8/6/13, 10/1/13, 1/15/14, and 2/12/14. By examination on 5/6/14 cervical paravertebral muscles were tender and spasms were present, and sensory sensation was reduced in the bilateral median nerve distribution. Cervical range of motion was as follows: flexion 38/55, extension 31/45, bilateral rotation 56/80, and bilateral lateral bending 28/40. Upper extremity muscle strength was 5/5 bilaterally, upper extremity deep tendon reflexes were 2+ bilaterally, and cervical compression and Spurling's were negative bilaterally. Shoulder was not tender to pressure. Shoulder range of motion was as follows: flexion bilaterally 90/180, extension bilaterally 30/30, internal rotation bilaterally 60/60, external rotation bilaterally 80/80, abduction bilaterally 90/180, and adduction bilaterally 45/45. Yergason's, Codman's arm drop, Apprehension, and Impingement Sign tests were negative bilaterally. Elbows were tender to palpation bilaterally. Range of motion was as follows: flexion bilaterally 140/140, extension bilaterally 180/180, supination bilaterally 85/85, and pronation bilaterally 75/75. Lateral Stability, Medial Stability, Golfers elbow/medial epicondyle and Tinel's tests were negative bilaterally, and Cozen's/lateral epicondyle was positive bilaterally. Wrist sensation was reduced in the bilateral median nerve distribution. Wrist ranges of motion were as follows: dorsal flexion bilaterally 65/65, palmar flexion bilaterally 70/70, ulnar deviation bilaterally 40/40, and radial deviation bilaterally 20/20. Finkelstein's test

was negative bilaterally, and Phalen's and Tinel's tests positive bilaterally. Thoracolumbar spasms were present. There were no sensory deficits of the lower extremities. Range of motion was reported as flexion 54/90, extension 18/30, bilateral rotation 18/30, bilateral lateral bending 18/30. Lower extremity muscle strength was 5/5 bilaterally. Lower extremity deep tendon reflexes were 2+ bilaterally, and sitting straight leg raise was positive bilaterally. The examination revealed essentially normal range of motion, negative Genu Varum and Genu Valgum, and positive McMurray's bilaterally. The patient was determined to be at maximum medical improvement as of 5/6/14.

IMR ISSUES, DECISIONS AND RATIONALES

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

Chiropractic treatment three (3) times a week for four (4) weeks for the neck, back, left shoulder, bilateral hands, elbows, knees: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 58-60. Decision based on Non-MTUS Citation Official Disability Guidelines.

Decision rationale: The MTUS Chronic Pain Medical Treatment Guidelines supports a 6-visit trial of manual therapy and manipulation over 2 weeks in the treatment of chronic low back pain complaints if caused by musculoskeletal conditions. With evidence of objective functional improvement, a total of up to 18 visits over 6-8 weeks as treatment for low back complaints may be considered. Elective/maintenance care is not medically necessary. Relative to recurrences/flare-ups of low back pain, there is the need to evaluate prior treatment success; if return to work has been achieved, then 1-2 visits every 4-6 months may be warranted. This patient was to begin chiropractic care on 9/4/11 and has treated on an unreported number of sessions to date without record of measured treatment response. In this case, there is no evidence of measured objective functional improvement with prior chiropractic care to the back, there is no evidence of a recurrence/flare-up, there is no evidence of a new condition, and elective/maintenance care is not supported to be medically necessary. Therefore, the request for additional chiropractic sessions to this patient's back is not supported by MTUS to be medically necessary. The MTUS does not support manual therapy and manipulation in the treatment of hand and knee complaints. The MTUS reports no recommendations for or against manual therapy and manipulation in the treatment of cervical, shoulder or elbow conditions; therefore, MTUS guidelines are not applicable in this case. The Official Disability Guidelines are the reference source for treatment of cervical, shoulder and elbow conditions; these guidelines do not support the request for additional chiropractic therapy for this patient's neck, shoulder or knees. In this case, there is no evidence of measured objective functional improvement with prior chiropractic care to neck, shoulder or elbow, there is no evidence of a recurrence/flare-up, there is no evidence of a new condition, and elective/maintenance care is not supported to be medically necessary. Therefore, the request is not medically necessary.