

Case Number:	CM14-0039169		
Date Assigned:	06/27/2014	Date of Injury:	09/06/2013
Decision Date:	07/31/2014	UR Denial Date:	03/27/2014
Priority:	Standard	Application Received:	04/03/2014

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 Chiropractics 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 48-year-old female born on [REDACTED]. On 09/06/2013 the patient reportedly tripped and fell on the edge of a pallet, hurting her right knee and left hand. On 10/23/2013 there was a request for chiropractic/physiotherapy modalities at a frequency of 2 times a week for 4 weeks. On 11/11/2013, the patient was seen in follow up pain management with complaints of constant right knee pain without measured objective factors reported, and diagnoses noted of right knee sprain/strain. The right knee MRI report of 12/17/2013 notes the impression as an abnormality of the posterior horn of the medial meniscus representing an oblique tear, a partial tear of the posterior portion of the posterior cruciate ligament, mild tendinitis of the quadriceps ligament, and bipartite patella. Left shoulder MRI of 12/18/2013 revealed a filed impingement syndrome, fluid is seen in the glenohumeral joint space and subdeltoid space, and tendinosis and edema of the rotator cuff with a partial tear beneath the acromion. Lumbar spine MRI of 12/22/2013 revealed a disc dessication at L4-L5, modic type II end plate degenerative changes at the inferior endplate of L4 and superior end plate of L5, 3. A L4-L5 broad based disc protrusion which causes stenosis of the spinal canal, bilateral neural foramen and bilateral lateral recess with contact on the visualized bilateral L5 transiting nerve roots, and a cystic focus in the right adnexal region which likely reflects an ovarian cyst. The hand completed chiropractor's progress report of 01/29/2014 reports right knee pain 9/10 and left shoulder pain 7/10. No measured objective examination factors are reported in diagnoses are noted as displacement of lumbar intervertebral disc without myelopathy, unspecified internal derangement of the, and left rotator cuff sprain/strain. There was a request for chiropractic/physiotherapy (specific treatment procedures not reported) at a frequency of 1 time per week for 4 weeks. Upper extremity electromyography performed on 03/06/2014 with the impression noted as essentially normal study of the bilateral upper extremities. Upper extremity nerve conduction studies were

performed on 03/07/2014 with the impression noted as normal study of the bilateral upper extremities. Records indicate the patient treated with chiropractic/physiotherapy on many occasions. There is no evidence of efficacy with chiropractic/physiotherapy care rendered and no evidence of an acute flare-up or new condition. There is a request for chiropractic/physiotherapy to the right knee, back, and left shoulder at a frequency of 3 times per week for 4 weeks.

IMR ISSUES, DECISIONS AND RATIONALES

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

Outpatient chiropractic/physiotherapy to right knee, back and left shoulder 3 times a week for 4 weeks: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Manual therapy & manipulation, Page(s): 58-60.. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Shoulder (Acute & Chronic), Procedure Summary - Manipulation, ODG Chiropractic Guidelines, Updated 04/25/2014.

Decision rationale: The request for chiropractic/physiotherapy at a frequency of 3 times per week for 4 weeks to the right knee, back and left shoulder is not supported to be medically necessary. The MTUS (Medical Treatment Utilization Guidelines) does not support manual therapy and manipulation in the treatment of knee conditions. MTUS reports the use of manual therapy and manipulation in treatment of the knee is not recommended. The request for chiropractic/physiotherapy at a frequency of 3 times per week for 4 weeks to the right knee is not supported to be medically necessary. In treatment of the low back, MTUS (Medical Treatment Utilization Guidelines) supports up to 6 visits during a 2-week trial of manual therapy and manipulation, with evidence of objective functional improvement a total of up to 18 visits over 6-8 weeks. 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. In this case, based on submitted documentation, the patient treated on 44 sessions of chiropractic/physiotherapy from 10/23/2013 through 05/21/2014. The patient has already treated in excess of MTUS recommendations in the care of back conditions. There is no evidence of measured objective functional improvement with chiropractic care rendered, there is no evidence of an acute flare-up or new condition, and elective/maintenance care is not medically necessary; therefore, the request for chiropractic/physiotherapy at a frequency of 3 times per week for 4 weeks to the back is not supported to be medically necessary. The MTUS (Chronic Pain Medical Treatment Guidelines) reports no recommendations for or against manual therapy and manipulation in the treatment of shoulder conditions; therefore, MTUS is not applicable. The ODG is the reference source, and ODG does not support medical necessity for the request for chiropractic/physiotherapy at a frequency of 3 times per week for 4 weeks to left shoulder. ODG Treatment, Shoulder (Acute & Chronic), Procedure Summary - Manipulation, ODG Chiropractic Guidelines: In the treatment of shoulder complaints ODG reports there is limited evidence to specifically support the utilization of manipulative procedures of the shoulder, but this procedure is routinely applied by chiropractic providers whose scope allows it,

and the success of chiropractic manipulation for this may be highly dependent on the patient's previous successful experience with a chiropractor. In general, it would not be advisable to use this modality beyond 2-3 visits if signs of objective progress towards functional restoration are not documented. ODG allows up to 9 visits over 8 weeks, with fading of treatment frequency (from up to 3 visits per week to 1 or less), plus active self-directed home therapy. The patient has already treated with chiropractic/physiotherapy care on 44 sessions from 10/23/2013 through 05/21/2014. There is no evidence of measured objective functional improvement with chiropractic care rendered, and there is no evidence of an acute flare-up or new condition; therefore, the request for chiropractic/physiotherapy at a frequency of 3 times per week for 4 weeks to the left shoulder is not supported to be medically necessary.