

Case Number:	CM14-0069341		
Date Assigned:	07/14/2014	Date of Injury:	05/05/2009
Decision Date:	09/16/2014	UR Denial Date:	04/15/2014
Priority:	Standard	Application Received:	05/14/2014

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 Anesthesiology, has a subspecialty in Pain Management and is licensed to practice in TENNESSEE. 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 53-year-old male who has submitted a claim for cervical degenerative disc disease and left shoulder rotator cuff tear associated with an industrial injury date of 05/05/2009. Medical records from 02/18/2014 to 07/14/2014 were reviewed and showed that patient complained of neck pain with radiation and numbness of the left upper extremity and left shoulder pain (pain scale grade not specified). Physical examination revealed diffuse tenderness over the paracervical muscles and trapezius and full ROM with pain. Left shoulder ROM was limited. Impingement signs were positive for the left shoulder. Motor, sensation, and reflexes of the left upper extremity were intact. MRI of left shoulder dated 02/28/2014 revealed supraspinatus tendon tear, subscapularis tendinosis, and downsloping acromion with subacromial osteophytes predisposing to impingement. MRI of the cervical spine dated 02/28/2014 revealed mild cervical degenerative disc disease C3-4, C4-5, and C6-7 with evidence of foraminal stenosis at C5-6 bilaterally and C3-4. X-ray of the cervical spine dated 06/18/2014 revealed anterior and posterior osteophytes and disc height loss C5-6 and C6-7. Treatment to date has included unspecified visits of physical therapy and pain medications. Utilization review dated 04/15/2014 denied the request for PT x 12 because the remaining slight deficits would be well addressed by HEP. Utilization review dated 04/15/2014 denied the request for chiropractic treatment x 12 because the report did not establish a flare up of the patient's chronic condition to indicate need for manipulation.

IMR ISSUES, DECISIONS AND RATIONALES

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

Physical therapy times 12 sessions: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Therapy Page(s): 98-99.

Decision rationale: According to pages 98-99 of the CA MTUS Chronic Pain Medical Treatment Guidelines, active therapy is recommended for restoring flexibility, strength, endurance, function, range of motion, and can alleviate discomfort. Patients are instructed and expected to continue active therapies at home as an extension of the treatment process in order to maintain improvement levels. Physical medicine guidelines allow for fading of treatment frequency from up to 3 visits per week to 1 or less plus active self-directed home physical medicine. In this case, the patient has completed unspecified visits of physical therapy with no documentation of functional outcome. It is unclear as to why the patient cannot self-transition into HEP. Moreover, the request failed to specify the body part to be treated. Therefore, the request for Physical therapy times 12 sessions is not medically necessary.

Chiropractic treatment times 12 sessions: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Manual therapy and manipulation.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Manual Therapy & Manipulation Page(s): 59-60.

Decision rationale: According to MTUS Chronic Pain Treatment Guidelines, manual therapy such as chiropractic care is widely used in the treatment of musculoskeletal pain. The intended goal or effect of Manual Medicine 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. The recommended initial therapeutic care for low back is a trial of 6 visits over 2 weeks, with evidence of objective functional improvement. If chiropractic treatment is going to be effective, there should be some outward sign of subjective or objective improvement within the first 6 visits. Chiropractic care is not recommended for other body parts other than low back. In this case, the request for chiropractic care did not specify the body part to be treated. The guidelines do not recommend chiropractic care for other body parts other than the lower back. Therefore, the request for Chiropractic treatment times 12 sessions is not medically necessary.