

Case Number:	CM14-0069970		
Date Assigned:	07/14/2014	Date of Injury:	05/14/2013
Decision Date:	08/21/2014	UR Denial Date:	05/10/2014
Priority:	Standard	Application Received:	05/15/2014

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 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 30-year-old male born on 09/13/1983. On 05/14/2013, the patient was moving a heavy refrigerator, estimated at 600 pounds, up a ramp with some coworkers and fell off of the hand truck landing on his back. He was taken by ambulance to a hospital where he was admitted with a compression fracture of T12 and abnormalities noted at T5 and T6. The patient underwent umbilical herniorrhaphy on 10/25/2013. The patient presented for chiropractic care on 03/20/2014 reporting upper back, mid back and low back pain. Objectively, DTRs in upper and lower extremities were 2+/5, dermatomal testing normal in lower extremities, dermatomal testing in upper extremities revealed decrease in sensation in the right C8 and T1 levels, cervical ROM within normal limits with the exception of flexion which revealed pain and stiffness in the right T3-T8 vertebral levels, lumbar ROM revealed a decrease in motion with flexion and left lateral flexion and pain and stiffness associated with all functions except right lateral flexion and left rotation, and Patrick Fabere and Kemp's were reported positive. Diagnoses were reported as pain and thoracic spine, thoracic compression fracture, neuralgia, and thoracic segmental dysfunction. The treatment was chiropractic care for 8 preauthorized visits. In the medical provider's 04/28/2014 PR-2, treatment included requesting 8 more chiropractic treatments. The chiropractor's progress report notes on exam date on 04/17/2014, the patient had complaints of upper back, mid back, and low back pain and stiffness. Objectively noted: paraspinal edema, intersegmental motion restrictions, spinous process tenderness, bilateral thermal asymmetries in the T3, T6, T 11, L5 and sacroiliac joint levels, range of motion restrictions, tenderness, and muscle guarding at the involved levels; with no measured objective factors reported. Diagnoses noted as pain in the thoracic spine, thoracic compression fracture, neuralgia, thoracic segmental dysfunction, and lumbar segmental dysfunction. The chiropractor requested authorization for an additional 8 visits within the next 6 weeks. The chiropractor's progress report notes on exam date

on 06/26/2014, the patient had complaints of upper back, mid back, and low back pain and stiffness. Objectively noted: paraspinal edema, intersegmental motion restrictions, spinous percussion tenderness, thermal asymmetries in the T3, T6, T11, L5 and sacroiliac joint levels, range of motion restrictions, tenderness, and muscle guarding at the involved levels; with no measured objective factors reported. Diagnoses noted as pain in the thoracic spine, thoracic compression fracture, neuralgia, thoracic segmental dysfunction, and lumbar segmental dysfunction. The chiropractor requested authorization for an additional 8 visits.

IMR ISSUES, DECISIONS AND RATIONALES

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

8 Chiropractic Manipulation treatments.: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Chiropractic treatment.

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 and Upper Back (Acute & Chronic), Procedure Summary - Manipulation.

Decision rationale: The request for 8 additional chiropractic treatment sessions to the upper back, mid back, and low back is not supported to be medically necessary. MTUS (Medical Treatment Utilization Guidelines) supports a trial of up to 6 visits over 2 weeks of manual therapy and manipulation in the treatment of chronic low back pain 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. MTUS (Chronic Pain Medical Treatment Guidelines) reports no recommendations for or against manual therapy and manipulation in the treatment of upper back and mid back conditions; therefore, MTUS guidelines are not applicable in this case relative to upper back and mid back complaints. Because MTUS does not specifically address the upper and mid back, ODG is the reference source relative to upper back and mid back complaints. 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 notes the patient has been treating with chiropractic care since 03/20/2014. The submitted documentation does not provide evidence of objective functional improvement with chiropractic care rendered, evidence of acute exacerbation, or evidence of a new condition, and elective/maintenance care is not supported; therefore, the request for 8 additional chiropractic treatment sessions exceeds MTUS and ODG Treatment Guidelines recommendations and is not supported to be medically necessary.