

Case Number:	CM14-0078150		
Date Assigned:	07/18/2014	Date of Injury:	08/14/2013
Decision Date:	10/01/2014	UR Denial Date:	05/26/2014
Priority:	Standard	Application Received:	05/28/2014

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 Physical Medicine & Rehabilitation 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:

This is a 35-year-old male with an 8/14/13 date of injury. The mechanism of injury occurred when the patient was loading different sized tires from the ground to a truck and felt a sharp pain in the low back. According to a handwritten progress report dated 4/23/14, the patient stated that her back pain is the worst, rated 6-7/10 and travelled to her leg. The pain was not improving. She rated her neck/shoulder pain as 6/10. A large portion of this note was illegible. Objective findings: limited ROM of lumbar spine, lumbar spine spasms, decreased sensation of leg, +SLR right leg. Diagnostic impression: left shoulder impingement, cervical spine multi disc pathology, lumbar spine disc disease with radiculitis to right leg. Treatment to date: medication management, activity modification, acupuncture. A UR decision dated 5/26/14 denied the requests for manual therapy 3xWk x 4Wks for neck, left shoulder, and low back and RETRO chiropractic with physiotherapy rehabilitation, therapeutic exercise. There is no documentation of significant pain reduction or objective measures of functional improvement noted with the previous treatments.

IMR ISSUES, DECISIONS AND RATIONALES

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

Manual therapy, three times a week for four weeks for neck, left shoulder and low back:
Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines
Page(s): 58-60.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 298-299, Chronic Pain Treatment Guidelines Low Back Complaints; Page(s): 58. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder Chapter

Decision rationale: CA MTUS states that manipulation appears safe and effective in the first few weeks of back pain without radiculopathy. In addition, a request to initiate treatment would make it reasonable to require documentation of objective functional deficits, and functional goals for an initial trial of 6 chiropractic/manipulation treatment. ODG states that there is limited evidence to specifically support the utilization of manipulative procedures of the shoulder and 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 demonstrated. It is unclear if the patient has had chiropractic treatment in the past. The patient reported low back pain that radiated to her legs. Guidelines do not support chiropractic treatment in the presence of radiculopathy. In addition, this request is for a total of 12 sessions of chiropractic treatment. Guidelines only support up to 6 sessions for an initial trial. Therefore, the request for Manual therapy, three times a week for four weeks for neck, left shoulder and low back was not medically necessary.

RETRO chiropractic with physiotherapy rehabilitation, therapeutic exercise: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 99, 46.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 57. Decision based on Non-MTUS Citation American College of Occupational and Environmental Medicine (ACOEM), 2nd Edition, (2004) Pain, Suffering, and the Restoration of Function Chapter, page 114

Decision rationale: CA MTUS states that manipulation is 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 objective measurable gains in functional improvement that facilitate progression in the patient's therapeutic exercise program and return to productive activities. Manipulation is manual therapy that moves a joint beyond the physiologic range-of-motion but not beyond the anatomic range-of-motion. It is unclear if the patient has had chiropractic treatment in the past. The quantity of chiropractic sessions requested is not noted. In addition, there is no documentation of the date of service being requested for this retrospective request. Since the date of service is not indicated, this request cannot be substantiated. Therefore, the request for RETRO chiropractic with physiotherapy rehabilitation, therapeutic exercise was not medically necessary.