

Case Number:	CM15-0106466		
Date Assigned:	06/10/2015	Date of Injury:	11/30/2014
Decision Date:	07/13/2015	UR Denial Date:	05/06/2015
Priority:	Standard	Application Received:	06/02/2015

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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:

State(s) of Licensure: California

Certification(s)/Specialty: Preventive Medicine, Occupational Medicine

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 injured worker is a 48 year old female who sustained an industrial injury on 11/30/14. The mechanism of injury is unclear. She currently complains of intermittent bilateral shoulder pain that radiates to bilateral arms and sides of the neck with numbness and tingling with a pain level of 6/10; intermittent bilateral calf pain that radiates to her bilateral heels and a pain level of 7/10; intermittent right ankle pain with no radiation and a pain level of 8/10. On physical exam there was tenderness to palpation on bilateral rotator cuffs and bilateral glenohumeral joints; there was tenderness on palpation of the right medial ankle, right Achilles tendon and right calcaneus. She takes naproxen, Prilosec and transdermal analgesic compounds. Medications decrease pain in all above mentioned areas. Diagnoses include right ankle arthralgia; right ankle ulceration; bilateral Achilles tendonitis; bilateral shoulder arthralgia. In the treatment plan dated 4/22/15 the treating provider's plan of care includes chiropractic treatments which include supervised physiotherapy and acupuncture therapy two times a week for six weeks; range of motion and muscle strength testing as tolerated.

IMR ISSUES, DECISIONS AND RATIONALES

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

Chiropractic physiotherapy, 2 times wkly for 6 wks, 12 sessions: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Manual Therapy & Manipulation Section Page(s): 58-61.

Decision rationale: Per the MTUS Guidelines, chiropractic care consisting of manual therapy and 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 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. A therapeutic trial of 6 visits over 2 weeks is recommended. If there is evidence of objective functional improvement, a total of up to 18 visits over 6 to 8 weeks is recommended. Elective or maintenance care is not recommended. Recurrences or flare ups should be evaluated for treatment success, and if return to work is achieved, 1-2 visits every 4-6 months is reasonable. However, this request is for 16 visits which is outside the recommendation of the guidelines. The request for chiropractic physiotherapy, 2 times wkly for 6 wks, 12 sessions is determined to not be medically necessary.

Acupuncture, 2 times wkly for 6 wks, 12 sessions: Upheld

Claims Administrator guideline: Decision based on MTUS Acupuncture Treatment Guidelines.

MAXIMUS guideline: Decision based on MTUS Acupuncture Treatment Guidelines.

Decision rationale: Per the MTUS Guidelines, chiropractic care consisting of manual therapy and 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 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. A therapeutic trial of 6 visits over 2 weeks is recommended. If there is evidence of objective functional improvement, a total of up to 18 visits over 6 to 8 weeks is recommended. Elective or maintenance care is not recommended. Recurrences or flare ups should be evaluated for treatment success, and if return to work is achieved, 1-2 visits every 4-6 months is reasonable. However, this request is for 16 visits which is outside the recommendation of the guidelines. The request for chiropractic physiotherapy, 2 times wkly for 6 wks, 12 sessions is determined to not be medically necessary.

Range of motion/ muscle testing: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints, Chapter 14 Ankle and Foot Complaints.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 350. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back Chapter/Flexibility Section.

Decision rationale: Per MTUS Guidelines, observing the patient's stance and gait is useful to guide the regional low back examination. In coordination or abnormal use of the extremities may indicate the need for specific neurologic testing. Severe guarding of low-back motion in all planes may add credence to a suspected diagnosis of spinal or intrathecal infection, tumor, or fracture. However, because of the marked variation among persons with symptoms and those without, range-of-motion measurements of the low back are of limited value. Per ODG, the use of range of motion testing is not recommended as a primary criterion, but should be a part of a routine musculoskeletal evaluation. The relation between lumbar range of motion measures and functional ability is weak or nonexistent. This has implications for clinical practice as it relates to disability determination for patients with chronic low back pain, and perhaps for the current impairment guidelines of the American Medical Association. The value of the sit-and-reach test as an indicator of previous back discomfort is questionable. The AMA Guides to the Evaluation of Permanent Impairment, 5th edition, state, "an inclinometer is the preferred device for obtaining accurate, reproducible measurements in a simple, practical and inexpensive way" (p 400). They do not recommend computerized measures of lumbar spine range of motion which can be done with inclinometers, and where the result (range of motion) is of unclear therapeutic value. ROM and muscle testing outside of a routine physician exam is not recommended, therefore, the request for range of motion/muscle testing is determined to not be medically necessary.