

<b>Case Number:</b>	CM15-0132711		
<b>Date Assigned:</b>	07/21/2015	<b>Date of Injury:</b>	04/30/2014
<b>Decision Date:</b>	08/17/2015	<b>UR Denial Date:</b>	07/02/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	07/09/2015

### 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: North Carolina  
 Certification(s)/Specialty: Family Practice

### 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 41-year-old male who sustained an industrial injury on 4-30-14. Diagnoses are rotator cuff syndrome-shoulder, thoracic rib segmental dysfunction, and cervical segmental dysfunction or somatic dysfunction. In a progress report dated 5-26-15, the treating physician notes subjective complaints of left anterior chest, axilla, and neck and shoulder pain. Objective findings note decreased cervical and left shoulder range of motion, tenderness of the axilla, acromioclavicular joint arthritis and supraspinatous tendonopathy. In a progress note dated 6-23-15, the treating physician notes positive shoulder depression and Soto Hall tests. The injured workers pain is reported to be moderate and intermittent to frequent and increased with upper body activity. The last chiropractic treatment was 6-9-15 and it has increased function, decreased pain, and increased range of motion and decreased inflammation. Previous treatment includes Acetaminophen, Ibuprofen, chiropractics and physical therapy. Work status is to return to full duty on 9-1-15. The requested treatment is six chiropractic manipulation sessions with myofascial release and mechanical traction and one subscapular and axillary nerve block.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Six (6) chiropractic manipulation sessions with myofascial release and mechanical traction:**  
 Overturned

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 173-174, Chronic Pain Treatment Guidelines Manual therapy & manipulation.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines manual manipulation Page(s): 58-59.

**Decision rationale:** The California chronic pain medical guidelines section on manual manipulation states: 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. Low back: Recommended as an option. Therapeutic care & Trial of 6 visits over 2 weeks, with evidence of objective functional improvement, total of up to 18 visits over 6-8 weeks. Elective/maintenance care & Not medically necessary. Recurrences/flare-ups & Need to reevaluate treatment success, if RTW achieved then 1-2 visits every 4-6 months. Ankle & Foot: Not recommended. Carpal tunnel syndrome: Not recommended. Forearm, Wrist, & Hand: Not recommended. Knee: Not recommended. Treatment Parameters from state guidelines a. Time to produce effect: 4 to 6 treatments Manual manipulation is recommended form of treatment for chronic pain. However, the requested amount of therapy sessions is in excess of the recommendations per the California MTUS. The California MTUS states there should be not more than 6 visits over 2 weeks and documented evidence of functional improvement before continuation of therapy. Previous chiropractic treatments have had documented objective improvements in pain and function per the records. Therefore, the request is medically necessary.

**One (1) subscapular and axillary nerve block:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 174-175.

**Decision rationale:** The ACOEM chapter on neck and upper back complaints states: Invasive techniques (e.g., needle acupuncture and injection procedures, such as injection of trigger points, facet joints, 2 or corticosteroids, lidocaine, or opioids in the epidural space) have no proven benefit in treating acute neck and upper back symptoms. However, many pain physicians believe that diagnostic and/or therapeutic injections may help patients presenting in the transitional phase between acute and chronic pain. Based on the lack of recommendations for the requested procedure, the request is not medically necessary.

