

<b>Case Number:</b>	CM15-0148218		
<b>Date Assigned:</b>	08/11/2015	<b>Date of Injury:</b>	07/25/2002
<b>Decision Date:</b>	09/14/2015	<b>UR Denial Date:</b>	07/09/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	07/30/2015

### 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: Physical Medicine & Rehabilitation

### 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 71 year old male, who sustained an industrial injury on 7-25-2002. Diagnoses include status post 7-01-2008 lumbar fusion L3-4 with metal instrumentation, recurring right sided lumbar radiculopathy, status post 10-12-2006 C4-C6 anterior cervical discectomy and fusion (ACDF) with metal instrumentation, chronic thoracic sprain or strain, cervical cephalgia and bilateral cervical radiculitis. Treatment to date has included surgical intervention as well as postoperative physical therapy and conservative treatment consisting of diagnostics, chiropractic care and massage therapy. Per the Primary Treating Physician's Progress Report dated 6-25-2015, the injured worker reported constant neck-ache rated as 5 out of 10, mid back pain that is worse on the right and rated as 6 out of 10, and constant low back pain that is described as sharp with movement and rated as 8 out of 10. He has noticed a progressive increase of right arm paresthesias and tingling in his left thumb as well as the right. Physical examination of the lumbar spine revealed marked tenderness to palpation of the rector spinae muscles, right greater than left with restricted lumbar ranges of motion. Cervical spine exam revealed marked rigidity to the posterior cervical musculature, right greater than left with reduced ranges of motion. Passive rotation extension causes increased pain to radiate down into the right parascapular and down the right arm. There was also marked tenderness in the mid-thoracic region, right greater than left. The plan of care included, and authorization was requested for additional chiropractic treatment (2 x 4) and additional massage (2 x 4).

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Chiropractic treatment, 2 times wkly for 4 wks, 8 sessions, additional:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Chiropractic Care, Manual Therapy & Manipulation, Treatment, Pages 58-60.

**Decision rationale:** MTUS Guidelines supports chiropractic manipulation for musculoskeletal injury. It is unclear how many sessions have been completed to date. Submitted reports have not demonstrated clear specific functional benefit or change in chronic symptoms and clinical findings for this chronic injury. There are unchanged clinical findings and functional improvement in terms of decreased pharmacological dosing with pain relief, decreased medical utilization, increased ADLs or improved functional status from treatment already rendered by previous chiropractic care. Clinical exam remains unchanged without acute flare-up or new red-flag findings. It appears the patient has received an extensive conservative treatment trial; however, remains unchanged without functional restoration approach. The Chiropractic treatment, 2 times wkly for 4 wks, 8 sessions, additional is not medically necessary and appropriate.

**Massage therapy, 2 times wkly for 4 wks, 8 sessions, additional:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Massage therapy Page(s): 60.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Massage therapy, page 60.

**Decision rationale:** Massage is recommended for time-limited use in subacute and chronic pain patients without underlying serious pathology and as an adjunct to a conditioning program that has both graded aerobic exercise and strengthening exercises; however, this is not the case for this chronic 2002 injury status post significant conservative physical therapy currently on an independent home exercise program. The patient has remained functionally unchanged. A short course may be appropriate during an acute flare-up; however, this has not been demonstrated nor are there any documented clinical change or functional improvement from treatment rendered previously. Without any new onset or documented plan for a concurrent active exercise program, criteria for massage therapy have not been established per MTUS Chronic Pain Guidelines. The Massage therapy, 2 times wkly for 4 wks, 8 sessions, additional is not medically necessary and appropriate.