

Case Number:	CM15-0204557		
Date Assigned:	10/21/2015	Date of Injury:	02/15/2015
Decision Date:	12/03/2015	UR Denial Date:	10/08/2015
Priority:	Standard	Application Received:	10/19/2015

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, Indiana, New York
 Certification(s)/Specialty: Internal 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 45 year old female who sustained an industrial injury on 2-15-15. The injured worker reported low back discomfort with lower extremity radiation. A review of the medical records indicates that the injured worker is undergoing treatments for shoulder, lumbar and thoracic sprain strain, cervical myofascitis and shoulder tenosynovitis. Provider documentation dated 7-22-15 noted the work status as temporary totally disabled. Treatment has included right shoulder magnetic resonance imaging (8-17-15), physical therapy, radiographic studies, chiropractic evaluation, and medication management. Objective findings dated 7-22-15 were notable for lumbar spine with decreased range of motion and tenderness to palpation with myospasms and guarding to the bilateral paravertebral musculature. The original utilization review (10-8-15) denied a request for Manual therapy 3x2 - spine (lumbar-cervical-thoracic).

IMR ISSUES, DECISIONS AND RATIONALES

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

Manual therapy 3x2 - spine (lumbar/cervical/thoracic): Upheld

Claims Administrator guideline: Decision based on MTUS Neck and Upper Back Complaints 2004, and Low Back Complaints 2004. Decision based on Non-MTUS Citation Official Disability Guidelines, Neck and Upper Back Chapter.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Manual therapy & manipulation. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain section, Manual therapy & manipulation.

Decision rationale: Pursuant to the Chronic Pain Medical Treatment Guidelines and the Official Disability Guidelines, manual therapy three times per week times two weeks to the spine (lumbar/cervical/thoracic) is not medically necessary. Manual manipulation and therapy is that recommended for chronic pain is caused by musculoskeletal conditions. The intended goal or effective manual medicine is the achievement of positive symptomatic or objective measurable gains and functional improvement. Manipulation, therapeutic care-trial of 6 visits over two weeks. With evidence of objective functional improvement, total of up to 18 visits over 6 to 8 weeks. Elective/maintenance care is not medically necessary. In this case, the injured worker's working diagnoses are lumbar spine sprain strain; radiculopathy; and myo-fasciitis. Date of injury is February 15, 2015. Request for authorization is dated September 18, 2015. According to the utilization review, the injured worker received 28 prior physical therapy sessions and 14 acupuncture sessions and an unspecified number of chiropractic treatments. A request for additional manual therapy was non-certified on August 7, 2015. According to a check the box (difficult to interpret) progress note on September 9, 2015, subjective complaints include low back pain. Objectively low back pain range of motion is decreased 45%. There is tenderness to palpation. There is no documentation demonstrating objective functional improvement from prior chiropractic (manual therapy), physical therapy or acupuncture. There are no compelling clinical facts indicating additional chiropractic (manual therapy) is clinically indicated. The guidelines recommend a six visit clinical trial with a total up to 18 visits over 6 to 8 weeks. As noted above, the total number of chiropractic treatments are not specified. Based on the clinical information medical record, peer-reviewed evidence-based guidelines, no documentation specifying the total number of chiropractic (manual therapy) treatments to date and no documentation demonstrating objective functional improvement, manual therapy three times per week times two weeks to the spine (lumbar/cervical/thoracic) is not medically necessary.