

<b>Case Number:</b>	CM14-0097296		
<b>Date Assigned:</b>	09/16/2014	<b>Date of Injury:</b>	07/18/2011
<b>Decision Date:</b>	11/03/2014	<b>UR Denial Date:</b>	06/06/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	06/25/2014

### 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 Licensed in Chiropractic, has a subspecialty in Acupuncture 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:

The injured worker is a 56 year old female who reported upper back and shoulder pain from injury sustained on 07/18/11 from lifting plywood out of green waste. There were no diagnostic imaging reports. Patient is diagnosed with adhesive capsulitis-shoulder, lumbar/lumbosacral disc degeneration, thoracic and cervical disc degeneration. Patient has been treated with medication, epidural injection, physical therapy, massage, chiropractic and acupuncture. Per medical notes dated 05/28/14, patient complain of thoracic pain under her right arm to the waist rated 8-10/10, right cervical pain radiates to her right jaw, ear, temple, and eye which is rated at 4-10/10. She also complains of right anterior shoulder, arm and medial forearm pain rated at 3/10 in the morning and increases to 7/10. Per notes dated 05/28/14 patient has been treated previously, she responded favorably then, last seen on 08/08/13; "she reported that her cervical and thoracic pain decreased 0-3/10 in intensity and she hadn't had a headache for over a month". Patient has had prior chiropractic treatments with symptomatic relief; however, clinical notes fail to document any functional improvement with prior care. Per medical notes dated 08/18/14, patient complains of upper back pain. Patient reports 50% pain relief on the right with epidural injection but the left side has gotten worse. Provider is requesting additional 12 chiropractic visits with myofascial release for flare-up which were modified to 6 by the utilization reviewer.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Six (12) Chiropractic Myofascial release treatments for the right cervical, thoracic, shoulder and arm: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Functional Improvement. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Massage Therapy

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines MANUAL THERAPY AND MANIPULATION; MASSAGE Page(s): 58-59; 60.

**Decision rationale:** Per MTUS- Chronic Pain medical treatment guideline - Manual therapy and manipulation pages 58-59. "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 objectively measureable gain sin functional improvement that facilitate progression in the patient's therapeutic exercise program and return to productive activities". 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. Reoccurrences/ flare-ups- need to re-evaluate treatment success, if RTW achieved then 1-2 visits every 4-6 months. Treatment parameters from state guidelines. A) Time of procedure effect: 4-6 treatments. B) Frequency 1-2 times per week the first 2 weeks as indicated by the severity of the condition. Treatment may continue at 1 treatment per week for the next 6 weeks. C) Maximum duration: 8 weeks. At 8 weeks patient should be re-evaluated. Care beyond 8 weeks may be indicated for certain chronic pain patients in whom manipulation has been helpful in improving function, decreasing pain and improving quality of life. Treatment beyond 4-6 visits should be documented with objective improvement in function". Per notes dated 05/28/14 patient has been treated previously, she responded favorably then, last seen on 08/08/13; "she reported that her cervical and thoracic pain decreased 0-3/10 in intensity and she hadn't had a headache for over a month". Patient has had prior chiropractic treatments with symptomatic relief; however, clinical notes fail to document any functional improvement with prior care. Provider is requesting additional 12 chiropractic visits with myofascial release for flare-up which were modified to 6 by the utilization reviewer. Per guidelines, functional improvement means either a clinically significant improvement in activities of daily living or a reduction in work restrictions as measured during the history and physical exam. Per MTUS guidelines: Massage, page60: This treatment should be an adjunct to other recommended treatments, and should be limited to 4-6 visits in most cases. "Myofascial release" is not documented in the guidelines. Requested visits exceed the quantity supported by guidelines. Per review of evidence and guidelines, 12 Chiropractic visits with myofascial release for Right Cervical, Thoracic, Shoulder and Arm are not medically necessary.