

Case Number:	CM15-0015489		
Date Assigned:	02/03/2015	Date of Injury:	05/05/2014
Decision Date:	03/27/2015	UR Denial Date:	12/24/2014
Priority:	Standard	Application Received:	01/27/2015

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, Hawaii
 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 29 year old male, who sustained an industrial injury on 04/28/2014. The diagnoses have included lumbar spine, right shoulder, cervical spine, right elbow, right arm, and right wrist sprain/strain, headache, numbness/paresthesia with cold lower extremities, neuritis/radiculitis to bilateral lower extremities, and lumbar disc protrusion. Treatments to date have included acupuncture, chiropractic therapy, and medications. Diagnostics to date have included MRI of the lumbar spine on 10/28/2014 which showed 1-2mm posterior disc bulge at L4-5 and L5-S1 without evidence of canal stenosis or neural foraminal narrowing. In a progress note dated 11/20/2014, the injured worker presented with complaints of low back pain. The treating physician reported decreased range to right shoulder. Utilization Review determination on 12/24/2014 non-certified the request for Chiropractic Treatment: 1x/week for 4-6 weeks (lumbar spine, right shoulder/wrist/hand), Acupuncture: 2x/week for 4-6 weeks (lumbar spine, right shoulder/wrist/hand), and Computerized ROM (range of motion) (lumbar spine, upper extremity) citing Medical Treatment Utilization Schedule Guidelines.

IMR ISSUES, DECISIONS AND RATIONALES

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

Chiropractic treatment for the lumbar spine, right shoulder, wrist and hand, 1 time a week for 4-6 weeks: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Manual therapy and manipulation.

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

Decision rationale: The patient presents with low back pain and right shoulder pain. The current request is for chiropractic treatment for the lumbar spine, right shoulder, wrist and hand, 1 x week 4-6 weeks. The treating physician states that right shoulder pain is intermittent moderate. The physician's reports submitted are mostly illegible. The MTUS guidelines state that manual therapy and manipulation is recommended for chronic pain if caused by musculoskeletal conditions. "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." "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 re-evaluate treatment success, if RTW achieved then 1-2 visits every 4-6 months." Furthermore, MTUS guidelines state that manual manipulation is not recommended for wrist and hand. In this case, the treating physician has not provided documentation as to any improvement in function and return to productive activities after 12 chiropractic visits thus far. The treating physician has also requested wrist and hand chiropractic care, which is not recommended per MTUS guidelines. The current request is not medically necessary and the recommendation is for denial.

Acupuncture for the lumbar spine, right shoulder, wrist and hand, 2 times a week for 4-6 weeks: Upheld

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

MAXIMUS guideline: Decision based on MTUS Acupuncture Treatment Guidelines.

Decision rationale: The patient presents with low back pain and right shoulder pain. The current request is for acupuncture for the lumbar spine, right shoulder, wrist and hand, 2 x week for 4-6 weeks. The treating physician states that right shoulder pain is intermittent moderate. The physician's reports submitted are mostly illegible. The AMTG guidelines allow 3-6 sessions of acupuncture treatments for lower back complaints for an initial trial and up to 1-3 sessions per week, 1-2 month with functional improvement. Acupuncture treatments may be extended if functional improvement is documented as defined in Section 9792.20(e). Labor code 9792.20(e) defines functional improvement as significant change in ADL's, OR change in work status such as return to work; AND decreased dependence on medical treatments. In this case, the patient has had 18 acupuncture sessions but the treating physician does not discuss the patient's response. Given the lack of discussion regarding functional improvement, additional acupuncture treatments would not be indicated. The current request is not medically necessary and the recommendation is for denial.

Computerized range of motion (ROM) for the lumbar spine and upper extremities (UE):
Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), TWC, Low back, Lumbar and thoracic (Acute & Chronic)

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG online guidelines, Computerized range of motion, low back

Decision rationale: The patient presents with low back pain and right shoulder pain. The current request is for computerized range of motion (ROM) for the lumbar spine and upper extremities (UE). The treating physician states that right shoulder pain is intermittent moderate. The physician's reports submitted are mostly illegible. The ODG guidelines state, "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." In this case, the treating physician has not established a need to measure ROM with a computer-assisted device. The current request is not medically necessary and the recommendation is for denial.