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| Case Number: | CM13-0005530 | | |
| Date Assigned: | 12/27/2013 | Date of Injury: | 07/07/2009 |
| Decision Date: | 02/24/2014 | UR Denial Date: | 07/09/2013 |
| Priority: | Standard | Application Received: | 08/01/2013 |

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Pain Management, has a subspecialty in Disability Evaluation 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 physician 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 claimant is a 56 year old male, with stated date of injury of August 19, 1996. This happened when he separated two male students during a fight on that date. He subsequently was seen by [REDACTED] of [REDACTED] and an MRI showed a large disc herniation on 9/9/96 at the L5-S1 level. He subsequently underwent a left L5-S1 modified discectomy, L5 hemilaminotomy, and left LS-S1 lateral recess resection on 9/27/96. The claimant has been under the care of treating physician for lumbar radiculopathy status post lumbar surgery and cervical spine stimulation. He was declared permanent and stationary as of 10/23/12. He had 33 percent whole person impairment. Work restrictions include preclusion of substantial work due to the fact that he had loss 75 percent of pre-injury capacity in performing lifting, pushing, pulling, climbing, and stooping. The patient should have access to future medical care to include, on basis chiropractic treatments to allow him to continue to function in his work capacity. He would need pain management evaluation and treatment, follow up with an orthopedic surgeon, prescriptions for medication, trigger point injections, physiotherapy, recurrent imaging studies and possible surgery. Treatment provisions could be made on a lifetime basis. Should the patient develop further impairment in his sleep management or internal medicine for long-term pain management and medication would be reasonable. The causation is industrial in origin, and apportionment was 100 percent to the industrial Medical report dated June 6, 2013 was provided for review. The claimant presented with complaints of worsening back pain. The claimant had chiropractic visits in May with some response. Because of his flare-up and worsening back symptoms he has not been able to continue working as it involves repetitive standing and walking as a school principal. Physical examination revealed cervical and lumbar paravertebral muscle tenderness and spasm. Cervical range o

IMR ISSUES, DECISIONS AND RATIONALES

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

Chiropractor Manj 3-4 Regions: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 58-60.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Chiropractic Care Page(s): 59.

Decision rationale: CA-MTUS (Effective July 18, 2009) page 59 of 127, regarding Chiropractic care: Number of Visits: Several studies of manipulation have looked at duration of treatment, and they generally showed measured improvement within the first few weeks or 3-6 visits of chiropractic treatment, although improvement tapered off after the initial sessions. If chiropractic treatment is going to be effective, there should be some outward sign of subjective or objective improvement within the first 6 visits. Active Treatment versus Passive Modalities: Manipulation is a passive treatment, but many chiropractors also perform active treatments, and these recommendations are covered under Physical therapy (PT), as well as Education and Exercise. The use of active treatment modalities instead of passive treatments is associated with substantially better clinical outcomes (Fritz, 2007). Active treatments also allow for fading of treatment frequency along with active self-directed home PT, so that less visits would be required in uncomplicated cases. The documentation provided for review does not support the need for additional supervised rehabilitation as opposed to transition to a self directed home exercise program. The medical necessity for chiropractic care is not supported for the following: 1) The documentation does not describe musculoskeletal deficits that would support the need of additional supervised rehabilitation 2) The documentation does not describe barriers to performance of a self directed home exercise program and 3) Sustained functional benefit with previous chiropractic care is not noted. Therefore, an Chiropractic Manipulation 3-4 Regions are not medically necessary.

Neuromuscular Re education: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 58-60.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation WiseGeek,(a team of researchers, writers and editors dedicated to providing short, clear and concise answers to common questions).

Decision rationale: CA-MTUS (Effective July 18, 2009) is mute about Neuromuscular Re-education. According to WiseGeek,(a team of researchers, writers and editors dedicated to providing short, clear and concise answers to common questions) Neuromuscular reeducation is defined as a general term that refers to techniques that attempt to retrain the neuromuscular system to function properly. The basis of this idea is that the formation of certain patterns of communication between muscles and nerves allow people to perform simple everyday acts such

as climbing stairs. These normal patterns of movement can be disrupted by injuries or may be impaired in people with certain medical conditions. The general aim is either to re-establish normal patterns of movement in injured people or to create normal patterns of movement in disabled people, by practicing a variety of exercises. People with specific injuries or challenges often seek out these techniques. This may include people who have experienced fractures or muscle tears or people with conditions like arthritis or cerebral palsy. Healthy people who want to improve their overall balance, strength, or flexibility, such as professional dancers or athletes, may also seek out certain forms of these therapies. At its most basic, neuromuscular reeducation is very similar to physical therapy and may involve many of the same techniques to promote healing. This can include one-legged standing exercises to improve balance, strengthening exercises that target a specific area of the body, or stretching routines to increase both flexibility and range of motion in an injured limb. Therapeutic massage may also be a part of these therapies. The claimant has received several sessions of chiropractic therapy as well as other therapeutic exercises, which should be sufficient to satisfy basic neuromuscular reeducation. Therefore the request for a separate neuromuscular reeducation is not medically necessary.

Massage Therapy: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 58-60.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 300, Chronic Pain Treatment Guidelines Physical Medicine Page(s): 25.

Decision rationale: ACOEM (2004) Chapter 9, page 300 states: Physical modalities such as massage, diathermy, cutaneous laser treatment, ultrasound, transcutaneous electrical neurostimulation (TENS) units, percutaneous electrical nerve stimulation (PENS) units, and biofeedback have no proven efficacy in treating acute low back symptoms. Insufficient scientific testing exists to determine the effectiveness of these therapies, but they may have some value in the short term if used in conjunction with a program of functional restoration. Insufficient evidence exists to determine the effectiveness of sympathetic therapy, a noninvasive treatment involving electrical stimulation, also known as interferential therapy. At-home local applications of heat or cold are as effective as those performed by therapists. CA-MTUS (effective July 18, 2009) page 25 of 127 states "Because of the limited benefits of therapy relative to massage, it is open to question whether this treatment acts primarily physiologically, but psychological factors may contribute substantially to the benefits observed (Erdogmus, 2007)." Therefore the request for massage therapy is not medically necessary since there is no documentation of any formal functional restoration program in place for this claimant based on the documentation provided for review

Therapy Procedure 1/> Areas EA 15 MI: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 58-60.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Manual Therapy and Manipulation Page(s): 58-60.

Decision rationale: California MTUS Chronic Pain Medical Treatment Guidelines, p. 58-60, Manual therapy & manipulation is 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 return to work (RTW) is 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 b. Frequency: 1 to 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 week 8, patients should be reevaluated. Care beyond 8 weeks may be indicated for certain chronic pain patients in whom manipulation is helpful in improving function, decreasing pain and improving quality of life. In these cases, treatment may be continued at 1 treatment every other week until the patient has reached plateau and maintenance treatments have been determined. Extended durations of care beyond what is considered "maximum" may be necessary in cases of re-injury, interrupted continuity of care, exacerbation of symptoms, and in those patients with comorbidities. Such care should be re-evaluated and documented on a monthly basis. Treatment beyond 4-6 visits should be documented with objective improvement in function. The claimant has received several sessions of active and passive Chiropractic manipulation, with no documentation of any functional improvement; therefore, the request for additional physical medicine modality is not medically necessary