

Case Number:	CM13-0063154		
Date Assigned:	12/30/2013	Date of Injury:	07/18/1996
Decision Date:	07/31/2014	UR Denial Date:	11/26/2013
Priority:	Standard	Application Received:	12/09/2013

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 Board Certified in Physical Medicine and Rehabilitation 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 69-year-old male who reported an injury on 07/18/1996. The mechanism of injury that incurred on 07/18/1996 was not noted within the documentation provided. Documented in the clinical note dated 11/19/2013, the injured worker complained of back and neck pain. Upon physical examination of the cervical spine, the documentation provided noted spasm, tenderness and tight muscle band bilaterally with palpation of the paravertebral muscles. Motor strength testing was normal. Physical examination of the lumbar spine noted bilaterally spasms, tenderness and tight muscle band on palpation of the paravertebral muscles. Motor strength testing was normal. The injured worker's diagnoses included lumbago, lumbosacral spondylosis without myelopathy, thoracic or lumbosacral neuritis or radiculitis not otherwise specified, and myalgia and mitosis not otherwise specified. The documentation provided did not indicate any physical therapy completed within the previous 12 months. The documentation provided noted the medications include Lidoderm 5% patch, lidogabaketo-TD 70 gm jar, Vicodin 5/500, aspirin 81 mg and Celebrex 200 mg. The provider request was for physical therapy twice a week for 4 weeks and chiropractic treatment, quantity 8. The request for authorization form dated 11/19/2013 was included within the documentation submitted for review. The rationale for the requested treatment was not noted within the documentation submitted for review.

IMR ISSUES, DECISIONS AND RATIONALES

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

PHYSICAL THERAPY TWICE A WEEK FOR FOUR WEEKS: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Page(s): 98-99.

Decision rationale: The California MTUS Guidelines state active therapy is based on the philosophy that therapeutic exercise and/or activity are beneficial for restoring flexibility, strength, endurance, function, range of motion, and can alleviate discomfort. Active therapy requires an internal effort by the individual to complete a specific exercise or task. This form of therapy may require supervision from a therapist or medical provider such as verbal, visual and/or tactile instructions. Patients are instructed and expected to continue active therapies at home as an extension of the treatment process in order to maintain improvement levels. Home exercise can include exercise with or without mechanical assistance or resistance in functional activities with assistive devices. The Guidelines further recommend to allow for a fading of treatment frequency (from up to 3 visits per week to 1 or less), plus active self-directed home physical medicine. The guidelines recommend 9 to 10 visits over 8 weeks for unspecified myalgia and myositis. The injured worker has a history of back and neck pain. As per the clinical note dated 11/19/2013, the injured worker complained of back and neck pain but stated that it does not stop him from doing any activity. The documentation also noted that the injured worker is still able to hike and weight train. There was a lack of documentation submitted to indicate any current functional deficits that would require physical therapy. There was also a lack of documentation to indicate that the current medication regimen was not providing adequate relief of symptoms and subsequently causing functional deficits. Based on the above noted documentation, the request for physical therapy twice a week for 4 weeks is not medically necessary.

CHIROPRACTIC TREATMENT, QUANTITY 8: 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 and Manipulation Page(s): 58.

Decision rationale: The California MTUS Guidelines recommend manual therapy and manipulation for the treatment of chronic low back pain if caused by musculoskeletal conditions. Therapeutic care is recommended at a trial of 6 visits over 2 weeks. Then, with objective functional improvement a total of up to 18 visits over 6 to 8 weeks. The injured worker has a history of back and neck pain. As per the clinical note dated 11/19/2013, the injured worker complained of back and neck but stated that it does not stop him from doing any activity. The documentation also noted that the injured worker is still able to hike and weight train. There was a lack of documentation submitted to indicate any current functional deficits that would require manual therapy and manipulation. There is also a lack of documentation to indicate that the current medicine regiment is not providing adequate relief of symptoms and subsequently

causing functional deficits. Based on the above noted documentation, the request for chiropractic treatment, quantity 8, is not medically necessary.