

<b>Case Number:</b>	CM13-0071944		
<b>Date Assigned:</b>	04/04/2014	<b>Date of Injury:</b>	01/10/2013
<b>Decision Date:</b>	05/27/2014	<b>UR Denial Date:</b>	12/12/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	12/30/2013

### 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 Occupational Medicine, 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 patient is an employee of [REDACTED] and has submitted a claim for cervical sprain, lumbar sprain, thoracic sprain, sacral sprain, knee sprain, and lumbar disc herniation associated with an industrial injury date of January 10, 2013. Treatment to date has included chiropractic care, physical therapy, knee immobilizer, and medications including tramadol ER, Voltaren XR, Flexeril, Protonix, and Flurbiprofen. Utilization review from December 12, 2013 denied the requests for one extremity manipulation, electro-muscle stimulation, myofascial release augmented with work conditioning / functional restoration between December 4, 2013 and January 20, 2014 because previous chiropractic care did not result to functional improvement in the form of decreased work restrictions and guidelines also do not support manipulation for the knee; and one request to continue with meds per [REDACTED] between December 4, 2013 and January 20, 2014 because the requesting physician, [REDACTED], did not prescribe the medications himself. Medical records from 2013 were reviewed showing that patient complained of frequent to less than frequent moderate pain within the right knee; frequent more than moderate but less than severe deep, dull achy pain within the cervical region; more than frequent moderate to more than moderate deep, dull achy pain within the thoracic region; constant more than moderate deep, dull achy pain within the lumbar region with radiation into the lower kinetic chain. Pain was graded 8/10 and aggravated by bending, lifting, prolonged standing, prolonged sitting, getting out of cars and chairs, sneezing, walking, coughing, and lying flat. She noted that the medication and chiropractic care allowed an increase in activities of daily living such as walking, prolonged standing and trips to the grocery store. Patient experienced some dizziness and stomach upset upon intake of Neurontin. Physical examination showed positive bilateral shoulder depression test, bilateral maximal foraminal compression test, cervical distraction test, Yeoman's test, right; Kemp's test, bilateral; Patrick's test, right; Nachlas test, right; varus and

valgus stress tests at the right knee; positive Valsalva, negative Hoover's and skin pinch test for symptom magnification. Cervical spine range of motion showed flexion 50/55, extension 35/45, left lateral bending 30/40, right lateral bending 40/40, left rotation 75/80, and right rotation 80/80. Lumbar spine range of motion showed flexion 50/90, extension 5/30, left lateral bending 20/30, right lateral bending 10/30, left rotation 20/30, and right rotation 20/30. Range of motion of right knee was recorded as 125/135 for flexion, and 10/0 for extension. Patient's gait remained altered. Patient presented with antalgic posture but has improved since treatment. Station and gait were also improved following treatment.

### **IMR ISSUES, DECISIONS AND RATIONALES**

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

#### **ONE EXTREMITY MANIPULATION, ELECTRO-MUSCLE STIMULATION, MYOFASCIAL RELEASE AUGMENTED WITH WORK CONDITIONING/FUNCTIONAL RESTORATION: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Manual Therapy And Manipulation. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Knee & Leg Chapter, and the Work Conditioning Guidelines Chapter.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 58-59, AND 125.

**Decision rationale:** As stated in the Chronic Pain Medical Treatment Guidelines, the intended goal 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. Maximum duration of therapy is 8 weeks. Treatment beyond this should be documented with objective improvement in function. In this case, the patient has started undergoing chiropractic care since March 31, 2013 which is beyond the maximum duration of therapy recommended. The total visits to chiropractic therapy are likewise unclear based on the medical records submitted. As stated in a progress report written on September 16, 2013, patient complained of frequent to less than frequent moderate pain within the right knee; which did not differ from a note dated October 28, 2013. Although there was noted increase in activities such as walking, prolonged standing, and trips to the grocery; the rest of the physical examination did not show any objective improvement. The findings for posture, station, and gait were only stated as improved following treatment without any precise description showing a development from the previous evaluation. Furthermore, as stated in the Chronic Pain Medical Treatment Guidelines, the criteria for admission to a Work Hardening Program includes: after treatment with an adequate trial of physical or occupational therapy with improvement followed by plateau; and a defined return to work goal agreed to by the employer and employee. In this case, a progress report, dated February 25, 2013, stated that patient underwent one session of physical therapy. It is unclear whether the patient continued attending treatment sessions or if she failed a trial of physical therapy. Moreover, the medical records submitted for review did not include documentation regarding a return to work goal agreement between the employer and employee. The guideline criteria have not been met. The request for

one extremity manipulation, electro-muscle stimulation, myofascial release augmented with work conditioning/functional restoration is not medically necessary or appropriate.

**CONTINUE WITH MEDS ACCORDING TO [REDACTED]:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 7-8.

**Decision rationale:** As stated in the Chronic Pain Medical Treatment Guidelines, using medications in the treatment of pain requires a thorough understanding of the mechanism underlying the pain as well as to identify comorbidities that might predict an adverse outcome. Choice of pharmacotherapy must be based on the type of pain to be treated and there may be more than one pain mechanism involved. Periodic review of the ongoing chronic pain treatment plan for the injured worker is essential. In this case, patient has been prescribed with tramadol ER, Voltaren XR, Flexeril, Protonix, and Flurbiprofen which provided relief of symptoms. However, the present request does not specify the exact medication, its dosage, and amount to dispense. Medications should be requested individually to allow determination of medical necessity for each. The request to continue with medications according to [REDACTED] is not medically necessary or appropriate.