

Case Number:	CM14-0003081		
Date Assigned:	01/31/2014	Date of Injury:	12/31/2008
Decision Date:	06/19/2014	UR Denial Date:	12/20/2013
Priority:	Standard	Application Received:	01/08/2014

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 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 patient is an employee of the county of [REDACTED] and has filed a claim for cervical discopathy with radiculitis associated with an industrial injury date of December 31, 2008. Treatment to date has included acupuncture, physical therapy, chiropractic sessions, oral pain medications, and home exercise program. Medical records from 2013 were reviewed showing the patient complaining of constant severe neck pain with radiating numbness and tingling to the bilateral upper extremities, right greater than the left. There is also low back pain that is aggravated by the usual activities. On examination, the patient's cervical spine has been essentially unchanged with tenderness over the cervical paravertebral muscles and upper trapezial muscle. Spasms were also noted. Axial loading compression test and Spurling's maneuver were positive. Cervical range of motion was restricted and painful. The bilateral shoulders had restricted range of motion. Impingment sign and Hawkin's sign were positive. The lumbar spine had tenderness as well as pain in terminal motion. There was dysesthesia at the L5 dermatome. Utilization review from December 20, 2013 denied the requests for physical therapy and chiropractic therapy due to no documentation of a flare up in the patient's chronic condition.

IMR ISSUES, DECISIONS AND RATIONALES

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

PHYSICAL THERAPY TWO TIMES PER WEEK FOR FOUR WEEKS: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation MTUS: CHRONIC PAIN MEDICAL TREATMENT GUIDELINES, PHYSICAL MEDICINE,

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation MTUS: CHRONIC PAIN MEDICAL TREATMENT GUIDELINES 2009, , 98-99

Decision rationale: As stated in the Chronic Pain Medical Treatment Guidelines, physical medicine is recommended and that treatment regimens should be tapered and transitioned into a self-directed home program. In this case, the patient had prior physical therapy but documentation concerning the response to this treatment was not provided. The patient's condition has been stable and there was no clinical evidence that the patient had an acute exacerbation. The request for physical therapy, two times per week for four weeks, is not medically necessary or appropriate.

CHIROPRACTIC CARE TWO TIMES PER WEEK FOR FOUR WEEKS: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation MTUS: CHRONIC PAIN MEDICAL TREATMENT GUIDELINES, MANUAL THERAPY & MANIPULATION, 58-60

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation MTUS: CHRONIC PAIN MEDICAL TREATMENT GUIDELINES 2009, , 58-60

Decision rationale: As stated in the Chronic Pain Medical Treatment Guidelines, manipulation is recommended for chronic pain caused by musculoskeletal conditions. Manipulation for the low back is recommended primarily as a trial of six visits and with evidence of objective functional improvement, a total of up to eighteen visits. In this case, the patient had prior chiropractic treatment in the past but the exact number of sessions completed as well as the response from this treatment was not clearly documented. The patient's condition is stable and does not warrant additional intervention. In addition, it is unclear which body part the chiropractic treatment will be directed to as not all areas have strong evidence for use. The request for chiropractic care, two times per week for four weeks, is not medically necessary or appropriate.