MAXIMUS Federal Services

Case Number:	CM14-0031235		
Date Assigned:	04/28/2014	Date of Injury:	11/02/2000
Decision Date:	07/21/2014	UR Denial Date:	01/28/2014
Priority:	Standard	Application Received:	02/03/2014

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 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 a 45-year-old male who has submitted a claim for cervicothoracic spine sprain/strain with herniated nucleus pulposus, bilateral wrist carpal tunnel syndrome, bilateral upper extremity overuse syndrome with lateral and medial epicondylitis, lumbar spine herniated nucleus pulposus with history of bilateral radiculopathy, and secondary stress, anxiety, and insomnia associated with an industrial injury date of November 2, 2000.Medical records from 2013-2014 were reviewed. The patient complained of persistent pain in the neck, mid back, low back, right shoulder, both elbows, and both wrists. The pain of the neck, elbow and wrist was grade 8 in severity while mid and low back pain was 7/10. He also reports having symptoms of stress, anxiety, and depression as well as difficulty falling asleep. Physical examination of the cervical spine showed tenderness over the lower paraspinal musculature, right greater than the left. There was also a palpable knot noted over the paracervical musculature. Range of motion was decreased. For the shoulders, Neer's test was positive bilaterally, more on the right. Elbow examination showed decreased range of motion of the right elbow on supination. Tinel's sign was positive, more on the right. Mill's test was positive on the right. Cozen's test was positive on the left. Wrist examination showed decreased range of motion on dorsiflexion of both wrists and palmar flexion of the right wrist. Tinel's sign was positive bilaterally and Finkelstein test was positive on the left. Lumbar spine examination showed tenderness over left thoracic paraspinal area and spinous processes at the levels of L2-L4. There is noted pain and limitation on extension. Imaging studies were not made available.Treatment to date has included medications, physical therapy, and activity modification,Utilization review, dated January 28, 2014, denied the request for physical therapy to include deep tissue manipulation once a week for 4 weeks because there was a concurrent request for a cervical traction unit, and it is felt that the outcome of this intervention should first be assessed prior to consideration of additional physical therapy

for this chronic condition. Furthermore, the nature, scope and outcome of prior physical therapy have not been elaborated to substantiate the current request for physical therapy at this stage of care. The request for CTLSO brace has been denied as well because there was no evidence of spinal instability to substantiate immobilization.

IMR ISSUES, DECISIONS AND RATIONALES

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

PHYSICAL THERAPY TO INCLUDE DEEP TISSUE MANIPULATION, ONCE A WEEK FOR 4 WEEKS: Upheld

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

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

Decision rationale: As stated on pages 98-99 of the CA MTUS Chronic Pain Medical Treatment Guidelines, a time-limited treatment plan with clearly defined functional goals, frequent assessment and modification of the treatment plan based upon the patient's progress in meeting those goals, and monitoring from the treating physician regarding progress and continued benefit of treatment is paramount. In this case, the patient previously underwent an unknown number of physical therapy sessions. The rationale of the request was because the patient has benefitted from physical therapy and deep tissue massage/manipulation in the past. The number of physical therapy sessions previously done by the patient for each body part to be treated is not clear. There was no documentation of the previous physical therapy visits and there was no description regarding objective benefits derived from these sessions or a treatment plan with defined functional gains and goals. It was also not documented why additional physical therapy is needed. Recent progress reports did not document any acute exacerbation or flare-up of symptoms. Patient is also expected to be well-versed in a self-directed home exercise program by now. Furthermore, the present request failed to specify the body part to be treated. Therefore, the request for PHYSICAL THERAPY TO INCLUDE DEEP TISSUE MANIPULATION, ONCE A WEEK FOR 4 WEEKS is not medically necessary.

CTLSO BRACE: Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 301. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back Chapter, Lumbar Supports.

Decision rationale: As stated on page 301 of the California MTUS ACOEM Low Back Chapter, lumbar supports have not been shown to have any lasting benefits beyond the acute phase of symptom relief and are recommended as an option for management of compression fractures,

spondylolisthesis, and instability. In addition, ODG states that lumbar supports are not recommended for prevention. In this case, the CTLSO brace was requested for support and to help alleviate some of his spine symptomatology. However, patient has persistent back pain which is beyond the acute phase. There is no evidence of lumbar fracture or instability. There was no evidence from the medical records that the patient suffered an acute exacerbation of the back pain. The medical necessity has not been established. Therefore, the request for CTLSO BRACE is not medically necessary.