

<b>Case Number:</b>	CM14-0068132		
<b>Date Assigned:</b>	07/11/2014	<b>Date of Injury:</b>	04/04/2011
<b>Decision Date:</b>	09/29/2014	<b>UR Denial Date:</b>	04/17/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	05/12/2014

### 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 Illinois. 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 58-year-old female who reported an injury on 04/04/2011. The mechanism of injury was not provided on 04/03/2014. The injured worker presented with pain in the lumbar spine, bilateral shoulders, bilateral hands, bilateral knees and bilateral ankles. Upon examination there was no change in range of motion, sensation or strength. The included physical therapy and chiropractic care and medications. Diagnoses were displacement of lumbar intervertebral disc without myelopathy, other specified disorder of bursae and tendons in the shoulder region, carpal tunnel syndrome, chondromalacia of the patella, other joint derangement not elsewhere classified involving the ankle and foot, pain in the joint involving multiple sites. A current medication list was not provided. The provider recommended physical therapy to the neck, chiropractic treatment, and IF unit and supplies, the provider's rationale was not provided. The Request for Authorization form was not included in the medical documents for review.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Physical therapy to neck, two sessions per week for four weeks:** 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 Physical Medicine Page(s): page(s) 98.

**Decision rationale:** The MTUS Chronic Pain Guidelines state that 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. Injured workers are instructed and expected to continue active therapies at home as an extension of the treatment process in order to maintain improvement levels. There is lack of documentation indicating the injured worker's prior course of physical therapy as well as the efficacy of prior therapy. The guidelines recommend 10 visits of physical therapy for up to 4 weeks. The amount of physical therapy visits that the injured worker already completed was not provided. Injured workers are instructed and expected to continue active therapies at home, there is no significant barrier to transitioning the injured worker to an independent home exercise program. There is a lack of objective functional deficits in the physical examination related to the neck to warrant physical therapy. As such, the request is not medically necessary.

**Chiropractic treatment to neck, two sessions per week for four weeks:** 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 Physical Medicine Page(s): page(s) 58.

**Decision rationale:** The MTUS Chronic Pain Guidelines state that 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. Injured workers are instructed and expected to continue active therapies at home as an extension of the treatment process in order to maintain improvement levels. There is lack of documentation indicating the injured worker's prior course of physical therapy as well as the efficacy of prior therapy. The guidelines recommend 10 visits of physical therapy for up to 4 weeks. The amount of physical therapy visits that the injured worker already completed was not provided. Injured workers are instructed and expected to continue active therapies at home, there is no significant barrier to transitioning the injured worker to an independent home exercise program. There is lack of objective functional deficits in the physical examination related to the neck to warrant physical therapy. As such, the request is not medically necessary.

**IF unit and supplies for 30 days, rental or purchase:** 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 Interferential Current Stimulation, Page(s): 118-119.

**Decision rationale:** The request for IF unit and supplies for 30 days rental or purchase is not medically necessary. The California MTUS Guidelines do not recommend IF unit as an isolated intervention. There is no quality evidence of effectiveness, except in conjunction with recommended treatments including return to work, exercise and medications, and maybe recommended if pain is ineffectively controlled by medications, medication intolerance, history of substance abuse, significant pain from postoperative conditions which limits the ability to perform exercise programs/physical therapy treatment or unresponsiveness to conservative measures. There is lack of evidence in the documentation provided that would reflect diminished the effectiveness of medications, history of substance abuse, or any postoperative conditions which would limit the injured worker's ability to perform exercise programs/physical therapy treatment. There was lack of documentation of injured worker's unresponsiveness to conservative measures. The requesting physician did not include an adequate and complete assessment of the injured worker's objective functional condition which would demonstrate deficits needing to be addressed as well as establish a baseline by which to assess objective functional improvement over the course of therapy. Additionally, the provider's request does not indicate the site at which the IF unit was indicated for in the request as submitted. As the IF unit is not warranted, the IF unit and supplies would not be medically necessary.