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| Case Number: | CM14-0208781 | | |
| Date Assigned: | 12/22/2014 | Date of Injury: | 03/10/2004 |
| Decision Date: | 02/10/2015 | UR Denial Date: | 11/18/2014 |
| Priority: | Standard | Application Received: | 12/12/2014 |

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 Rehab, 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:

This 41 year-old patient sustained an injury on 3/10/2004 from leaning over while lifting. Request(s) under consideration include [REDACTED] Rehab Program twice a week for a total of 24 sessions and Chiropractic treatment x 2x4 lumbar spine only. Diagnoses include lumbar facet syndrome/ lumbar radiculitis; disorder of bursae and tendon in shoulder/ rotator cuff syndrome; and chronic pain syndrome. Conservative care has included medications, therapy, and modified activities/rest. The patient continues to treat for chronic ongoing pain symptoms. Report of 11/7/14 from the provider noted the patient with continued pain in the shoulder and low back rated at 10/10; narcotic medication for pain management. Exam showed unchanged findings of tenderness to palpation at spine area without reported neurological deficits described. Treatment included rehab program of physical therapy and chiropractic treatment. The request(s) for [REDACTED] Rehab Program twice a week for a total of 24 sessions was denied and Chiropractic treatment x 2x4 lumbar spine only was modified for 6 sessions on 11/18/14 citing guidelines criteria and lack of medical necessity.

IMR ISSUES, DECISIONS AND RATIONALES

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

[REDACTED] Rehab Program twice a week for a total of 24 sessions: Upheld

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

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

Decision rationale: Submitted reports have no acute flare-up or specific physical limitations to support for physical therapy for this chronic injury of 2004. Physical therapy is considered medically necessary when the services require the judgment, knowledge, and skills of a qualified physical therapist due to the complexity and sophistication of the therapy and the physical condition of the patient. There is unchanged chronic symptom complaints, clinical findings, and work status. There is no evidence documenting functional baseline with clear goals to be reached and the patient striving to reach those goals. It is unclear how many PT sessions the patient has received or what functional outcome was benefited if any. The Chronic Pain Guidelines allow for 9-10 visits of physical therapy with fading of treatment to an independent self-directed home program. It appears the patient has received prior sessions of PT without clear specific functional improvement in ADLs, work status, or decrease in medication and utilization without change in neurological compromise or red-flag findings to support further treatment. The [REDACTED] Rehab Program twice a week for a total of 24 sessions is not medically necessary and appropriate.

Chiropractic treatment x 6 lumbar spine only: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Chiropractic Care, Manual Therapy & Manipulation, Treatment Page(s): 58-60.

Decision rationale: MTUS Guidelines supports chiropractic manipulation for musculoskeletal injury. The intended goal is the achievement of positive musculoskeletal conditions via positive symptomatic or objective measurable gains in functional improvement that facilitate progression in the patient's therapeutic exercise program and return to productive activities. It is unclear how many sessions have been completed to date. Submitted reports have not demonstrated clear specific functional benefit or change in chronic symptoms and clinical findings for this chronic injury. There are unchanged clinical findings and functional improvement in terms of decreased pharmacological dosing with pain relief, decreased medical utilization, increased ADLs or improved functional status from previous chiropractic treatment already rendered. Clinical exam remains unchanged without acute flare-up, new red-flag findings, or new clinical findings to support continued treatment consistent with guidelines criteria. It appears the patient has received previous conservative treatment trial for this 2004 injury with recent modified authorization for 6 sessions; however, remains functionally unchanged. The Chiropractic treatment 2x4 lumbar spine only is not medically necessary and appropriate.