

Case Number:	CM15-0023965		
Date Assigned:	02/13/2015	Date of Injury:	09/23/1997
Decision Date:	04/02/2015	UR Denial Date:	01/15/2015
Priority:	Standard	Application Received:	02/09/2015

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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:

State(s) of Licensure: California

Certification(s)/Specialty: Physical Medicine & Rehabilitation

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 72 year old male, who sustained an industrial injury on 9/23/1997. The diagnoses have included neck pain and lumbar and cervical, thoracic, and lumbar degenerative disc disease. Treatment to date has included conservative measures. Currently, the injured worker complains of severe and constant neck pain, going across shoulders, like a knife in back. He also reported severe and frequent low back pain, waking him up at night. Decreased range of motion was noted to all cervical motions, with spasms in neck and shoulder. Chiropractic manipulation, accompanied by physical therapy, was recommended to reduce pain and inflammation and increase range of motion and function. A previous Utilization report, dated 9/09/2014, certified chiropractic manipulation, accompanied by physical therapy (1x6) for the cervical/thoracic/lumbar spine. The specific dates or results of prior chiropractic manipulation with physical therapy were not documented. On 1/15/2015, Utilization Review non-certified a request for chiropractic for lumbar and/or sacral vertebrae (6), and non-certified a request for physical therapy for the lumbar and/or sacral vertebrae (6), citing MTUS Chronic Pain Medical Treatment Guidelines.

IMR ISSUES, DECISIONS AND RATIONALES

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

Chiropractic for the lumbar and/or sacral vertebrae: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Manual Therapy & Manipulation Page(s): 58-60.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Manual Therapy and Manipulation Page(s): 58-59.

Decision rationale: The patient presents with pain and weakness in his neck and lower back. The request is for Chiropractic For The Lumbar And/Or Sacral Vertebrae. MTUS Manual Therapy and Manipulation guidelines pages 58, 59 state that treatment is recommended for chronic pain if caused by musculoskeletal conditions. For the low back it is recommended as an option. For Therapeutic care a trial of 6 visits over 2 weeks, with evidence of objective functional improvement, with a total of up to 18 visits over 6-8 weeks is allowed. In this case, the utilization review letter on 09/09/14 indicates that the patient has completed 15 sessions of chiropractic treatment and additional 6 sessions were certified. None of the reports discuss how the patient has responded to the treatment. The treater requested chiropractic treatment "to reduce pain/ inflammation and to increase ROM/ function." The combination of 15 sessions the patient already received and 6 sessions authorized on 09/09/14 already exceeded what is allowed per MTUS for this kind of condition. Furthermore, the treater does not indicate how many sessions of chiropractic treatment are being requested. The request IS NOT medically necessary.

Physical Therapy for the lumbar and/or sacral vertebrae 1 time a week for 6 weeks:
Upheld

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

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

Decision rationale: The patient presents with pain and weakness in his neck and lower back. The request is for 6 Sessions Of Physical Therapy. For non-post- operative therapy treatments, MTUS guidelines page 98 and 99 allow 8-10 sessions for neuralgia, neuritis, and radiculitis, unspecified and 9-10 sessions for myalgia and myositis, unspecified. In this case, the utilization review letter on 09/09/14 indicates that 6 sessions of physical therapy were certified. The treater requested physical therapy "to reduce pain/ inflammation and to increase ROM/ function." None of the reports discuss how many physical therapy the patient has had and how the patient has responded to the physical therapy in terms of pain reduction or functional improvement. The treater does not explain why the patient is unable to transition into a home program. The current request for 6 combined with 6 already authorized would exceed what is recommended per MTUS guidelines. The request of physical therapy IS NOT medically necessary.