

<b>Case Number:</b>	CM14-0182690		
<b>Date Assigned:</b>	11/07/2014	<b>Date of Injury:</b>	01/09/2014
<b>Decision Date:</b>	12/16/2014	<b>UR Denial Date:</b>	10/24/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	11/03/2014

### 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 Family 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:

This injured worker's date of injury is 01/09.2014. Initially, the patient experienced a fall while seated on a chair, which resulted in a head, neck, and right shoulder injury. The patient received work activity restrictions, physical therapy, home exercises, and medications. Other documentation states the patient received manual therapy, electrical stimulation, and myofascial release. The documentation includes some hand written hard to read clinical notes showing treatments of the low back, leg, shoulder, and cervical spine from March 2014 through June 2014.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Office visit, Qty: 1:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines: Office visits

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain, Office visits

**Decision rationale:** The guidelines do allow for medical fously visits in the office to refill medications and to monitor how the patient is responding to interventions and treatment. The reason for the visit is not stated clearly in the documentation. There is no clear statement about

the nature of the visit is or what diagnosis or diagnoses for which the patient needs monitoring and re-evaluating. The request for office visit is not medically necessary.

**Chiropractic treatment, unspecified frequency/duration, lumbar/thoracic, Qty: 1:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Manual therapy & manipulation Page(s): 58-59.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Manual therapy & manipulation Page(s): 58-60.

**Decision rationale:** The patient has received treatment physical therapy and chiropractic already; however, the documentation is not clear about the response to the passive therapy. Maintenance care is not covered. The patient ought to be performing active home exercises at this time. For treatment of the low back, a trial of 6 visits over 2 weeks, if there is evidence of functional improvement, is covered. This request does not specify frequency or duration of the treatment. Additional chiropractic treatment is not medically necessary.

**Extraspinal therapy, unspecified frequency/duration, lumbar/thoracic, Qty: 1:** 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 Manual therapy & manipulation Page(s): 58-60.

**Decision rationale:** The patient has received treatment physical therapy, chiropractic, and myofascial release already; however, the documentation is not clear about the patient's response to the passive therapy. Maintenance care is not covered. The patient ought to be performing active home exercises at this time. For treatment of the low back, a trial of 6 visits over 2 weeks is recommended, if there is evidence of functional improvement. The request does not include specifics of frequency or duration. Additional extraspinal treatment is not medically necessary.

**Manual therapy techniques, unspecified frequency/duration, lumbar/thoracic, Qty: 1:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Manual therapy & manipulation Page(s): 58-59.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Manual therapy & manipulation Page(s): 58-60.

**Decision rationale:** The patient has received treatment physical therapy, chiropractic, and myofascial release already; however, the documentation is not clear about the patient's response to the passive therapy. Maintenance care is not covered. The patient ought to be performing active home exercises at this time. For treatment to be continued, there must be evidence of

functional improvement. The request does not include specifics of frequency or duration. Additional manual therapy is not medically necessary.

**Myofascial release, unspecified frequency/duration, lumbar/thoracic, Qty: 1: 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 Manual therapy & manipulation Page(s): 58-60.

**Decision rationale:** The patient has received treatment physical therapy, chiropractic, and myofascial release already; however, the documentation is not clear about the patient's response to the passive therapy. Maintenance care is not covered. The patient ought to be performing active home exercises at this time. For treatment to be continued, there must be evidence of functional improvement. The request does not include specifics of frequency or duration. Additional myofascial release treatment is not medically necessary.

**Electrical stimulation, unspecified frequency/duration, lumbar/thoracic, Qty: 1: 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 Electrical stimulators (E-stim) Page(s): 45.

**Decision rationale:** This patient receives treatment for low back pain and other musculoskeletal pain. There are a number of transcutaneous treatment modalities, each with a different indication. This request is vague as to the nature of the treatment as well as the frequency and duration of the planned treatment. The patient has received treatment physical therapy, chiropractic, and myofascial release already; however, the documentation is not clear about the patient's response to the passive therapy. Maintenance care is not covered. Electrical stimulation is not medically necessary.