

<b>Case Number:</b>	CM14-0217670		
<b>Date Assigned:</b>	01/07/2015	<b>Date of Injury:</b>	12/04/2013
<b>Decision Date:</b>	03/09/2015	<b>UR Denial Date:</b>	12/11/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	12/29/2014

### 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. 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, Pain Management

### 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's date of injury was December 4, 2013. The diagnoses for this worker include knee sprain/strain, hip sprain, hip pain, joint dysfunction of the lower extremity, lumbar and thoracic spine pain, and facet syndrome. The disputed and issues of this case include a request for chiropractic treatment and physical therapy. A utilization review determination on December 11, 2014 had noncertified these requests. The rationale stated for the denial of chiropractic therapy was that evidence-based guidelines indicate that this physical mentality is not efficacious in this clinical syndrome. With regard to the physical therapy request, there was no documentation of significant progress from prior therapy today. Therefore, the reviewer concluded that continued therapy is not supported.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Chiropractic treatment x6:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG Chiropractic Guidelines

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

**Decision rationale:** The Chronic Pain Medical Treatment Guidelines state on pages 58-60 the following regarding manual therapy & manipulation: Recommended for chronic pain if caused by musculoskeletal conditions. Manual Therapy is widely used in the treatment of musculoskeletal pain. The intended goal or effect of Manual Medicine is the achievement of positive symptomatic or objective measurable gains in functional improvement that facilitate progression in the patient's therapeutic exercise program and return to productive activities. Manipulation is manual therapy that moves a joint beyond the physiologic range-of-motion but not beyond the anatomic range-of-motion. Low back: Recommended as an option. Therapeutic care - Trial of 6 visits over 2 weeks, with evidence of objective functional improvement, total of up to 18 visits over 6-8 weeks. Elective/maintenance care - Not medically necessary. Recurrences/flare-ups - Need to re-evaluate treatment success, if RTW achieved then 1-2 visits every 4-6 months. Ankle & Foot: Not recommended. Carpal tunnel syndrome: Not recommended. Forearm, Wrist, & Hand: Not recommended. Knee: Not recommended. Treatment Parameters from state guidelines a. Time to produce effect: 4 to 6 treatments b. Frequency: 1 to 2 times per week the first 2 weeks, as indicated by the severity of the condition. Treatment may continue at 1 treatment per week for the next 6 weeks. c. Maximum duration: 8 weeks. At week 8, patients should be reevaluated. Care beyond 8 weeks may be indicated for certain chronic pain patients in whom manipulation is helpful in improving function, decreasing pain and improving quality of life. In these cases, treatment may be continued at 1 treatment every other week until the patient has reached plateau and maintenance treatments have been determined. In the case of this request, it is unclear where the chiropractic manipulation is being directed. This was requested in a progress note on date of service December 1, 2014. An appeal letter on December 2, 2014 clarifies that the hip, knee, and back will be treated. The MTUS specifically recommend against manipulation treatment in the knee, and therefore this request is not medically necessary. For future requests, the provider should specify the body regions are to be manipulated.

**Physical therapy x8:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG Physical Medicine Guidelines

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

**Decision rationale:** In the case of this injured worker, the submitted documentation indicates the patient has completed physical therapy in the past, but the number of past visits, functional benefit from prior therapy, and a comprehensive summary of past therapy is not submitted. This information is crucial to justify future PT. The Chronic Pain Medical Treatment Guidelines recommend that formal physical therapy should be tapered to self-directed home exercises. Therefore, additional physical therapy is not medically necessary.

