

Case Number:	CM14-0156407		
Date Assigned:	09/25/2014	Date of Injury:	11/16/2011
Decision Date:	11/05/2014	UR Denial Date:	09/18/2014
Priority:	Standard	Application Received:	09/24/2014

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 Orthopedic Surgery, has a subspecialty in Sports Medicine and is licensed to practice in Alaska and Texas. 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 11/16/2011. The mechanism of injury was not provided. The Diagnostic studies included a nerve conduction study. Prior therapies included physical therapy and chiropractic treatment. The injured worker's medications included Tramadol 50 mg. The documentation of 08/04/2014 revealed the injured worker had pain in the lumbar spine without radiation. The injured worker had complaints of weakness in the right lower extremity. The documentation indicated the injured worker underwent an EMG/nerve conduction study on 06/16/2014, which revealed all nerve conduction studies were within normal limits, however, the injured worker had a mild right L5-S1 radiculopathy. The physical examination revealed the injured worker had decreased range of motion and had a positive toe and negative heel walk. The injured worker had positive paraspinal tenderness to percussion. The diagnoses included musculoligamentous sprain and strain of the lumbar spine, lumbosacral instability, and lumbar radiculopathy right leg by history not current complaint, and gait derangement. The treatment plan included a refill of medications, durable medical equipment including a cane, and a course of chiropractic and physiotherapy twice a week for 6 weeks for the lumbar spine. There was no documented rationale for the requested treatments. There was no Request for Authorization form submitted for review.

IMR ISSUES, DECISIONS AND RATIONALES

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

Chiropractic/ Physiotherapy 2 x 6 week- lumbar spine: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Physical Therapy , lumbar sprains and strains

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines MANUAL THERAPY; PHYSICAL MEDICINE Page(s): 58-59; 98-99.

Decision rationale: The California MTUS Guidelines indicate that manual therapy and manipulation is recommended for chronic pain if it is caused by musculoskeletal conditions. The treatment for flare-ups requires re-evaluation of prior treatment successes. The clinical documentation submitted for review failed to indicate the quantity of sessions previously attended as well as the objective functional benefit. The request for chiropractic care would not be supported. The California MTUS Guidelines recommend physical therapy for up to 10 visits for radiculitis. The clinical documentation submitted for review indicated the injured worker had previously undergone physical therapy. There was a lack of documentation of objective functional benefit that was received. There was a lack of documentation indicating the injured worker had objective functional deficits that would respond to supervised care. The request would exceed guideline recommendations for physiotherapy. Given the above, the request for chiropractic/physiotherapy 2 times a week x 6 weeks lumbar spine is not medically necessary.