

Case Number:	CM14-0009183		
Date Assigned:	02/14/2014	Date of Injury:	12/03/2003
Decision Date:	06/24/2014	UR Denial Date:	01/06/2014
Priority:	Standard	Application Received:	01/23/2014

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 and rehabilitation, 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:

According to the records made available for review, this is a 38-year-old female with a December 3, 2003 date of injury. At the time of request for authorization for chiropractic therapy 2 x 4 weeks - L/S, CS and MRI without contrast right knee (December 19, 2013), there is documentation of subjective (persistent low back pain, moderate to severe neck pain, difficulty sleeping, and pain in the right knee with episodes of clicking and locking with occasional swelling) and objective (cervical tenderness, limited cervical range of motion, lumbar tenderness, knee joint line tenderness, and positive patellar compression test) findings, current diagnoses (cervical spine myofascitis with radiculitis, lumbar spine facet syndrome, and right knee sprain/strain), and treatment to date (sixteen chiropractic visits completed to date and medications). Medical report identifies that MRI of the knee is being requested to rule out a questionable medial meniscal tear to the right knee. Regarding chiropractic therapy, there is no documentation of exceptional factors to justify exceeding guidelines and functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications or medical services as a result of previous chiropractic treatments completed to date. Regarding MRI of the knee, there is no documentation of nondiagnostic radiographs.

IMR ISSUES, DECISIONS AND RATIONALES

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

CHIROPRACTIC THERAPY 2 X 4 WEEKS - L/S, CS: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation MTUS: LOW BACK COMPLAINTS, CHAPTER 12 LOW BACK COMPLAINTS,

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation MTUS: AMERICAN COLLEGE OF OCCUPATIONAL AND ENVIRONMENTAL MEDICINE (ACOEM), 2ND EDITION, (2004) , LOW BACK COMPLAINTS AND NECK & UPPER BACK COMPLAINTS, 289-299, 181

Decision rationale: The ACOEM Practice Guidelines identifies documentation of objective improvement with previous treatment, functional deficits, functional goals, and a statement identifying why an independent home exercise program would be insufficient to address any remaining functional deficits, as criteria necessary to support the medical necessity of additional chiropractic treatment. In addition, The Chronic Pain Medical Treatment Guidelines supports a total of up to eighteen visits over six to eight weeks. Furthermore, MTUS-Definitions identifies that any treatment intervention should not be continued in the absence of functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications or medical services as a result of previous chiropractic treatments completed to date. Within the medical information available for review, there is documentation of diagnoses of cervical spine myofasciitis with radiculitis, lumbar spine facet syndrome, and right knee sprain/strain. In addition, there is documentation of 16 previous chiropractic sessions completed to date. However, given that the proposed number of chiropractic sessions, in addition to the treatment already completed, would exceed guidelines, there is no documentation of exceptional factors to justify exceeding guidelines. In addition, there is no documentation of functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications or medical services as a result of previous chiropractic treatments completed to date. The request for chiropractic therapy, lumbar and cervical spine, twice weekly for four weeks, is not medically necessary or appropriate.

MRI WITHOUT CONTRAST RIGHT KNEE: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation MTUS: KNEE COMPLAINTS , CHAPTER 13

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation MTUS: AMERICAN COLLEGE OF OCCUPATIONAL AND ENVIRONMENTAL MEDICINE (ACOEM), 2ND EDITION, (2004) , KNEE, 344-347

Decision rationale: The ACOEM Practice Guidelines identifies documentation of an unstable knee with documented episodes of locking, popping, giving way, recurrent effusion, or clear signs of a bucket handle tear, as well as nondiagnostic radiographs, as criteria necessary to support the medical necessity of MRI of the knee. ODG identifies documentation of a condition/diagnosis (with supportive subjective/objective findings) for which an MRI of the knee

is indicated (such as: acute trauma to the knee, including significant trauma, or if suspect posterior knee dislocation or ligament or cartilage disruption; Nontraumatic knee pain; initial anteroposterior and lateral radiographs nondiagnostic; patellofemoral (anterior) symptoms; initial anteroposterior, lateral, and axial radiographs nondiagnostic; nontrauma, non-tumor, non-localized pain; or initial anteroposterior and lateral radiographs demonstrate evidence of internal derangement), as criteria necessary to support the medical necessity of MRI of the knee. Within the medical information available for review, there is documentation of diagnoses of cervical spine myofascitis with radiculitis, lumbar spine facet syndrome, and right knee sprain/strain. In addition, there is documentation of an unstable knee with documented episodes of clicking and locking and recurrent effusion and a request for MRI of the knee to rule out a questionable medial meniscal tear to the right knee. However, there is no documentation of nondiagnostic radiographs. The request for an MRI without contrast on the right knee is not medically necessary or appropriate.