

Case Number:	CM14-0012076		
Date Assigned:	03/12/2014	Date of Injury:	02/01/2010
Decision Date:	06/30/2014	UR Denial Date:	12/31/2013
Priority:	Standard	Application Received:	01/30/2014

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 & Rehabilitation, has a subspecialty in Pain Medicine and is licensed to practice in Texas and Ohio. 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 62-year-old male who reported an injury on 02/01/2011, due to an unknown mechanism. The clinical note dated 12/09/2013 the injured worker presented with complaints of weakness involving his right elbow and difficulty with prolonged weight bearing activities involving his lumbar spine. The injured worker's physical exam revealed paraspinal muscle tenderness with painful range of motion and his right elbow revealed a well-healed incision. The injured worker was diagnosed with a history of an industrial injury to the right knee, patellofemoral chondromalacia of the right knee, medial and lateral meniscal tears with osteochondral injury of the right knee, status post right knee diagnostic and operative arthroscopy with a date of surgery of 09/10/2010, grade 4 chondromalacia of the lateral compartment of the left knee based on MRI studies, left knee status post diagnostic and operative arthroscopy with arthroscopic meniscectomy, debridement, and chondroplasty on 05/06/2011, status post aspiration of the left knee on 07/06/2011, left knee Synvisc 1 injection on 09/26/2011, status post right knee Synvisc 1 viscosupplementation injection on 11/04/2011, bilateral knee Synvisc injection on 04/16/2012, future medical care permanent and stationary as per [REDACTED] on 03/23/2012, status post bilateral knee Synvisc 1 injection on 11/26/2012, status post Synvisc 1 for the bilateral knees on 08/05/2013, cubital tunnel syndrome of the right elbow, and status post right elbow cubital tunnel release and anterior subcutaneous ulnar nerve transposition on 10/25/2013. The provider recommended chiropractic treatment to the lumbar spine 2 times a week for 6 weeks and physical therapy to the right elbow 2 times a week for 6 weeks. The Request for Authorization Form is dated 12/17/2013. The provider's rationale for the request was not provided in the documents for review.

IMR ISSUES, DECISIONS AND RATIONALES

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

CHIROPRACTIC TREATMENT TO LUMBAR SPINE 2 X 6 WEEKS.: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ACOEM Guidelines, Chapter 6: Pain And Suffering, And The Restoration Of Function, Page 114

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

Decision rationale: The request for chiropractic treatment to the lumbar spine 2 times a week for 6 weeks is non-certified. The California MTUS Guidelines recommend chiropractic treatment for chronic pain caused by musculoskeletal conditions. Manual therapy is widely used in the treatment of musculoskeletal pain. The intended goal or effect of manual medicine is achieving a positive symptomatic or objective measurable gains in functional improvement that facilitate progress in the injured worker's therapeutic exercise program and return to work activities. Manual therapy for low back pain has a recommendation of six visits over 2 weeks with evidence of objective functional improvement. The included medical documents reference prior chiropractic treatment for the injured worker. There is no evidence of exhaustion of conservative measures such as NSAIDs and physical therapy. The amount of completed chiropractic treatments is unclear; there is a lack of documentation to support future chiropractic treatments, which would have included increase of function, decrease in medication, and decrease in pain. As such, the request is not medically necessary.

PHYSICAL THERAPY TO RIGHT ELBOW 2 X 6 WEEKS: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ACOEM Guidelines, Chapter 6: Pain And Suffering, And The Restoration Of Function, Page 114

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

Decision rationale: The request for physical therapy to the right elbow 2 times a week for 6 weeks is non-certified. The California MTUS Guidelines state that active therapy is based on a philosophy that therapeutic exercise and/or activity are beneficial for restoring flexibility, strength, endurance, function, range of motion, and can alleviate discomfort. Active therapy requires an internal effort by the individual to complete a specific exercise or task. There was lack of documentation indicating the injured worker's prior course of physical therapy as well as efficacy of the prior therapy. The goals of physical therapy treatment were unclear. The guidelines allow for up to 10 visits of physical therapy; the amount of physical therapy visits that have already been completed for the right elbow is unclear. Therefore, the request is not medically necessary.

