

Case Number:	CM14-0025081		
Date Assigned:	06/11/2014	Date of Injury:	02/04/2011
Decision Date:	07/15/2014	UR Denial Date:	02/06/2014
Priority:	Standard	Application Received:	02/27/2014

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, Pain Medicine and is licensed to practice in 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 33 year old male whose date of injury is 02/04/2011. The mechanism of injury is not described. EMG/NCV dated 08/31/13 is a normal study. Initial report dated 09/21/13 indicates that the injured worker complains of pain in the lower back. Diagnoses are lumbar spine disc herniation with myelopathy, and lumbar radiculitis with radiculopathy to both lower extremities. MRI of the lumbar spine dated 01/29/14 revealed 2 mm posterior disc bulge at L3-4 without evidence of central stenosis or neural foraminal narrowing. At L4-5 there is a posterior annular tear within the intervertebral disc. At L5-S1 there is a posterior annular tear within the intervertebral disc.

IMR ISSUES, DECISIONS AND RATIONALES

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

24 SESSIONS CHIROPRACTIC/PHYSICAL THERAPY / MODALITY THERAPY:

Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Manual Therapy and Manipulation Page(s): 58-60.

Decision rationale: Based on the clinical information provided the request for 24 sessions chiropractic/physical therapy/modality therapy are not recommended as medically necessary. There is no comprehensive assessment of treatment completed to date or the injured worker's response thereto submitted for review. Chronic Pain Medical Treatment Guidelines would support 1-2 visits every 4-6 months for recurrence/flare-up and note that elective/maintenance care is not medically necessary. There is no current, detailed physical examination submitted for review and no specific, time-limited treatment goals are provided.