

Case Number:	CM14-0067751		
Date Assigned:	07/11/2014	Date of Injury:	01/02/2009
Decision Date:	09/26/2014	UR Denial Date:	04/09/2014
Priority:	Standard	Application Received:	05/12/2014

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 Family Medicine and is licensed to practice in Texas and Mississippi. 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 50 year old female who reported a date of injury of 01/02/2009. The mechanism of injury was not indicated. The injured worker had diagnoses of cervical radiculopathy, cervical sprain/strain, lumbar radiculopathy, lumbar sprain/strain and left carpal tunnel syndrome. Prior treatments included the use of a wrist brace and localized intense neural stimulation therapy. Diagnostic studies and surgical history were not provided within the medical records received. The injured worker had complaints of neck pain and stiffness radiating to the upper extremities bilaterally, low back pain radiating to lower extremities bilaterally, and stiffness. The clinical note dated 07/10/2014 noted the injured worker had tenderness to palpation of the cervical paravertebral muscles and spinous process and tenderness to palpation of the coccyx, lumbar paravertebral muscles, sacrum, and spinous processes. Straight leg raise caused pain bilaterally. Medications included Ibuprofen, Flexeril and topical pain creams. The plan of treatment included recommendations for a pain management consult, aqua-therapy and combined modality therapy. The rationale and request for authorization form were not provided within the medical records received.

IMR ISSUES, DECISIONS AND RATIONALES

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

Pool Therapy two (2) times a week for four (4) weeks: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines aquatic therapy Page(s): 22.

Decision rationale: The request for pool therapy two times a week for four weeks is not medically necessary. The injured worker had complaints of neck pain and stiffness radiating to the upper extremities bilaterally, low back pain and stiffness radiating to the lower extremities bilaterally and bilateral wrist pain and stiffness. The California MTUS guidelines note aquatic therapy is recommended as an optional form of exercise therapy, where available, as an alternative to land based physical therapy. Aquatic therapy (including swimming) can minimize the effects of gravity, so it is specifically recommended where reduced weight bearing is desirable, for example extreme obesity. The guidelines recommend 8-10 sessions over 4 weeks with an initial clinical trial of of the amount of the suggested course of therapy sessions in order to demonstrate objective functional improvement with therapy prior to the continuation of therapy. The clinical findings indicated the injured worker does have tenderness to palpation in the cervical and lumbar spine. There is a lack of documentation indicating the injured worker has significant objective functional deficits for which therapy would be indicated. However, there is a lack of documentation indicating the injured worker has a condition which would warrant the need for reduced weight bearing exercises. As such, the request is not medically necessary.

Initial Chiropractic Therapy Once a week for two (2) weeks, cervical and lumbar: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Page(s): 114. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG).

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

Decision rationale: The request for initial chiropractic therapy once a week for two weeks, cervical and lumbar is not medically necessary. The injured worker had complaints of neck pain and stiffness radiating to the upper extremities bilaterally, low back pain radiating to lower extremities bilaterally, and stiffness. The California MTUS guidelines recommend chiropractic therapy for chronic pain caused by musculoskeletal conditions. There should be some outward signs of subjective or objective improvement within the first 6 visits, if chiropractic treatment is going to be effective. The guidelines recommend as an option a trial of 6 visits over 2 weeks and with evidence of objective functional improvement, total of up to 18 visits over 6-8 weeks. The guidelines support chiropractic treatment for acute injury or flare ups, however, elective/maintenance care is not supported. There is a lack of documentation indicating whether the injured worker has had any prior chiropractic treatment, as well as the efficacy of any prior chiropractic treatment. There is a lack of documentation indicating the injured worker has significant objective functional deficits for which treatment would be indicated. As such, the request is not medically necessary.