

Case Number:	CM14-0067816		
Date Assigned:	07/23/2014	Date of Injury:	10/11/2012
Decision Date:	09/17/2014	UR Denial Date:	04/21/2014
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 Physical Medicine & Rehabilitation and Pain Medicine 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:

The injured worker is a 47-year-old male who reported injury on 10/11/2012. The mechanism of injury was not submitted in report. The injured worker has diagnoses of lumbar spine sprain/strain with myospasm, bilateral knee sprain/strain, and medication induced gastritis. Past medical treatment consists of physical therapy, acupuncture, the use of a TENS unit, aquatic relief system, chiropractic therapy, and medication therapy. Medications include Cyclobenzaprine 10 mg, Naproxen 550 mg, Pantoprazole 20 mg, Tramadol ER 150 mg, and transdermal compounds. There is no duration or frequency noted on medications. X-rays of the lumbar spine, right knee and left knee were obtained on 02/14/2014. Impression of the lumbar spine was mild straightening of the lumbar curvature compatible with lumbar myositis. No fracture. The right knee and left knees were radiologically negative. The injured worker complained of low back pain. He described it as constant and rated it as moderate to occasionally severe. He stated that the pain radiated to his hips. There was no numbness or tingling sensation but he reported stiffness. The injured worker described the pain in his knees as worsening which he rated as moderate to occasionally severe. He stated that his pain radiated to his knees from his lower back and that he also had numbness and tingling sensation of both his legs. There was no measurable pain levels documented in the submitted report. Physical examination dated 04/03/2014 revealed that the injured worker's thoracolumbar spine was normal kyphosis, slight scoliosis and normal lordosis. He had tenderness to palpation with spasms of the paraspinals and tenderness to palpation of the bilateral sacroiliacs. He had limited range of motion secondary to pain. Pinwheel sensory dermatomes L1 through S1 were intact. Deep tendon reflexes of the patellar L4 and Achilles S1 were 2+ bilaterally. Examination of the knees revealed that he had tenderness to palpation of the medial knees bilaterally. He also had limited range of motion secondary to pain. There was a positive McMurray's test and a negative

drawer and varus/valgus stress test. The treatment plan was for the injured worker to continue medication and have additional sessions of chiropractic therapy and physical therapy. The rationale was not submitted for review. The request for authorization forms were submitted on 04/03/2014 for chiropractic sessions and physical therapy.

IMR ISSUES, DECISIONS AND RATIONALES

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

12 Additional Chiropractic Sessions, Lumbar: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines: Chiropractic Treatment.

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

Decision rationale: The California Medical Treatment Utilization Schedule (MTUS) guidelines recommend Chiropractic therapy for chronic pain if caused by musculoskeletal conditions. Chiropractic therapy is manual therapy that moves a joint beyond the physiologic range-of-motion but not beyond the anatomic range-of-motion. It is recommended for low back. Not recommended for ankle, foot, carpal tunnel syndrome, forearm, wrist hand and knee. Treatment parameters from state guidelines stipulate that it takes 4 to 6 treatments to produce effect, 1 to 2 times per week the first 2 weeks then treatment may continue at 1 treatment per week for the next 6 weeks. Maximum duration of 8 weeks. Given the guidelines above, the injured worker is not within the MTUS Guidelines. The report submitted had no evidence of chronic pain caused by musculoskeletal conditions. The injured worker complained of low back pain. He described it as constant and rated it as moderate to occasionally severe. He stated that the pain radiated to his hips. There was no numbness or tingling sensation but he reported stiffness. The injured worker described the pain in his knees as worsening which he rated as moderate to occasionally severe. He stated that his pain radiated to his knees from his lower back and that he also had numbness and tingling sensation of both his legs. There was no measurable pain levels documented in the submitted report. There was no evidence showing that the injured worker would not benefit from a home exercise program. Furthermore, the injured worker has already completed sessions of chiropractic therapy with the request of an additional 12 sessions. There was not quantified documented evidence showing if the sessions benefited the injured worker or not or what the outcomes were of such sessions. The guidelines recommend 1 treatment session per week for 6 weeks. The request did not specify the frequency of the visits. The request as submitted exceeds the recommended guidelines for chiropractic therapy. As such, the request for 12 additional chiropractic sessions of the lumbar spine is not medically necessary.

12 Additional Physical Therapy Sessions, Lumbar: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines: Physical Therapy.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Page(s): 99.

Decision rationale: The California MTUS Guidelines may support 9-10 visits of physical therapy for the treatment of unspecified myalgia and myositis to promote functional improvement. The documentation indicated that she had previous physical therapy. The report lacked details regarding his prior treatment, including number of visits completed and objective functional gains of pain were not provided. There was also lack of documentation indicating why continued therapy is needed and why an independent home exercise program would not be sufficient to address the remaining functional deficits. The injured worker complained of low back pain. He described it as constant and rated it as moderate to occasionally severe. He stated that the pain radiated to his hips. There was no numbness or tingling sensation but he reported stiffness. The injured worker described the pain in his knees as worsening which he rated as moderate to occasionally severe. He stated that his pain radiated to his knees from his lower back and that he also had numbness and tingling sensation of both his legs. There was no measurable pain levels documented in the submitted report. Based on the lack of objective evidence of functional improvement with previous visits, the appropriateness for additional physical therapy cannot be established. Furthermore, the request failed to indicate who often the visits were planned for. Therefore, due to the lack of documentation regarding previous physical therapy and when the physical therapy would be given was not specified in the request, the request is not supported. As such, the request for 12 additional physical therapy sessions of the lumbar spine is not medically necessary.