

Case Number:	CM14-0178388		
Date Assigned:	10/31/2014	Date of Injury:	06/01/2009
Decision Date:	03/30/2015	UR Denial Date:	09/26/2014
Priority:	Standard	Application Received:	10/27/2014

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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:
 State(s) of Licensure: New Jersey, Michigan, California
 Certification(s)/Specialty: Neurology, Neuromuscular Medicine

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 56 year old female, who sustained an industrial injury on 6/01/2009. The diagnoses have included chronic low back pain, lumbar radiculopathy and lumbago. Treatment to date has included physical therapy, chiropractic, medication, and activity modification. Magnetic resonance imaging (MRI) dated 8/14/2012 of the right hip revealed a right femoral neck fracture. MRI of the lumbar spine dated 8/14/2012 revealed multilevel disc bulges. She underwent a right hip hemiarthroplasty on 8/14/2012. EMG (electromyography)/NCV (nerve conduction studies) dated 3/22/2013 was compatible with radiculitis on the right. Currently, the IW complains of low back, tailbone and right hip pain. Objective findings included an antalgic gait favoring the right leg. There is tenderness over the lumbar spinous processes and interspinous ligaments with restricted range of motion. Examination of the right hip revealed restricted range of motion and a positive Trendelenburg test on the right. On 9/26/2014, Utilization Review non-certified a request for chiropractic evaluation and treatment (1x4) for the hip and low back, educational class for injury prevention x 1 session and orthopedic shoes noting that the clinical findings do not support the medical necessity of the treatment. The MTUS, ACOEM Guidelines and ODG were cited. On 10/27/2014, the injured worker submitted an application for IMR for review of chiropractic evaluation and treatment (1x4) for the hip and low back and orthopedic shoes.

IMR ISSUES, DECISIONS AND RATIONALES

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

Chiropractic evaluation and treatment once a week for four weeks for the hip and low back: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines.

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

Decision rationale: According to MTUS guidelines, Manual therapy & manipulation:< Recommended for chronic pain if caused by musculoskeletal conditions. Manual Therapy is widely used in the treatment of musculoskeletal pain. The intended goal or effect of Manual Medicine is the achievement of positive symptomatic or objective measurable gains in functional improvement that facilitate progression in the patient's therapeutic exercise program and return to productive activities. Manipulation is manual therapy that moves a joint beyond the physiologic range-of-motion but not beyond the anatomic range-of-motion. Low back: Recommended as an option. Therapeutic care - Trial of 6 visits over 2 weeks, with evidence of objective functional improvement, total of up to 18 visits over 6-8 weeks. Elective/maintenance care - Not medically necessary. Recurrences/flare-ups - Need to reevaluate.>Based on the above, continuous chiropractic treatment is not recommended without periodic documentation of its efficacy. There is no documentation of the efficacy of previous chiropractic sessions. Therefore, the request for Chiropractic evaluation and treatment once a week for four weeks for the hip and low back is not medically necessary.

Orthopedic shoes: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 14 Ankle and Foot Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines ankle and foot chapter

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Special Studies and Diagnosis and Treatment Considerations Page(s): 372-375.

Decision rationale: According to MTUS, supportive shoes are medically necessary in several disease of the ankle and foot. There is no documentation that this patient developed foot disorder. Therefore, the indication of orthopedic shoes is not medically necessary.