MAXIMUS Federal Services

| Case Number: | CM15-0104135 | | |
|---|---|---|---|
| Date Assigned: | 06/08/2015 | Date of Injury: | 07/19/1999 |
| Decision Date: | 07/08/2015 | UR Denial Date: | 05/20/2015 |
| Priority: | Standard | Application Received: | 06/01/2015 |

## 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: Maryland
Certification(s)/Specialty: Physical Medicine & Rehabilitation, 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 61-year-old female injured worker suffered an industrial injury on 07/19/1999. The diagnoses included bilateral carpal tunnel syndrome, cervical discopathy, lumbar discopathy/ facet arthropathy and bilateral knee internal derangement. On 4/15/2015, the treating provider reported there was constant pain in the cervical spine with radiations to the upper extremities associated with headaches that are migrainous in nature rated as 7/10. There was constant pain in the low back with radiations to the lower extremities rated 7/10. There was frequent pain in the bilateral wrists rated 6/10. There was frequent pain in the knees, left greater than right that was worsening rated 7/10. The treatment plan included Chiropractic therapy, Physical Therapy and Inversion Table.

## IMR ISSUES, DECISIONS AND RATIONALES

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

**Chiropractic for flare-up; eight (8) visits (2 x 4), cervical and lumbar spine:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Manual therapy & manipulation.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Manual therapy & manipulation Page(s): 58-60.

**Decision rationale:** Chiropractic for flare-up; eight (8) visits (2 x 4), cervical and lumbar spine is not medically necessary per the MTUS Guidelines. The MTUS recommends a trial of 6 visits over 2 weeks, with evidence of objective functional improvement, total of up to 18 visits over 6-8 weeks. For recurrences/flare F ups, the MTUS recommends reevaluate treatment success, and if return to work is achieved then 1-2 visits every 4-6 months. The documentation indicates that the patient has had prior chiropractic treatment, however it is unclear how many visits the patient has had and the outcome of these visits. Without clarification of this information additional chiropractic treatments are not medically necessary.

**Physical Therapy; eight (8) sessions (2 x 4), cervical spine, lumbar spine and wrists:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine. Decision based on Non-MTUS Citation Official Disability Guidelines, Preface, and Physical Therapy Guidelines.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Physical medicine Page(s): 98-99.

**Decision rationale:** Physical Therapy; eight (8) sessions (2 x 4), cervical spine, lumbar spine and wrists is not medically necessary per the MTUS Chronic Pain Medical Treatment Guidelines. The MTUS recommends up to 10 visits for this patient's condition. The documentation indicates that the patient has had prior therapy, however it is unclear how many visits of therapy the patient has had for each body part and the outcome of this therapy. Without this information, the request for additional physical therapy is not medically necessary.

**Inversion Table:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines, Low Back Chapter, and Home Inversion Table.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 300. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low back-Traction.

**Decision rationale:** The request for an inversion table is not medically necessary per the ODG and the MTUS Guidelines. The MTUS states that traction has not been proved effective for lasting relief in treating low back pain. Because evidence is insufficient to support using vertebral axial decompression for treating low back injuries, it is not recommended. The ODG states that it does not recommend using powered traction devices, but home-based patient controlled gravity traction may be a noninvasive conservative option, if used as an adjunct to a program of evidence-based conservative care to achieve functional restoration. As a sole treatment, traction has not been proved effective for lasting relief in the treatment of low back

pain. The MTUS Guideline and ODG evidence suggests that any form of traction may not be effective. The guidelines do not recommend traction and the documentation does not give extenuating circumstances, which would necessitate an inversion table. The patient should be competent in an independent home exercise program for the low back. The request for an inversion table is not medically necessary.