MAXIMUS Federal Services

Case Number:	CM15-0139810		
Date Assigned:	07/29/2015	Date of Injury:	03/07/2013
Decision Date:	08/27/2015	UR Denial Date:	07/07/2015
Priority:	Standard	Application Received:	07/20/2015

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: California
Certification(s)/Specialty: Emergency 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:

This is a 45 year old male with a March 7, 2013 date of injury. A progress note dated June 11, 2015 documents subjective complaints (burning, radicular lower back pain and muscle spasms; pain rated at a level of 5 out of 10; pain travels down both legs, associated with numbness and tingling, left greater than right; weakness of the left leg; pain aggravated by activities of daily living), objective findings (antalgic gait; pain with heel walking, greater on the left; tenderness to palpation over the lower lumbar spine with paravertebral spasms; sciatic notch tenderness; decreased range of motion of the lumbar spine; positive straight leg raise on the left; slightly decreased sensation to pinprick and light touch at the L5 and S1 dermatomes bilaterally; motor strength is decreased in all the represented muscle groups in the bilateral lower extremities), and current diagnoses (lower back pain; lumbar spine herniated nucleus pulposus; lower extremity radiculitis). Treatments to date have included medications, extracorporeal shock wave therapy, imaging studies, and chiropractic treatments. The medical record indicates that medications offer temporary relief of pain and improve ability to have restful sleep. The treating physician documented a plan of care that included chiropractic treatment and aqua therapy.

IMR ISSUES, DECISIONS AND RATIONALES

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

Chiropractic treatment 3 times a week for 6 weeks: Upheld

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

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

Decision rationale: The requested chiropractic treatment 3 times a week for 6 weeks is not medically necessary.CA MTUS Chronic Pain Treatment Guidelines, Manual Therapy and Manipulation, Pages 58-59, recommend continued chiropractic therapy with documented objective evidence of derived functional benefit. The treating physician has documented subjective complaints (burning, radicular lower back pain and muscle spasms; pain rated at a level of 5 out of 10; pain travels down both legs, associated with numbness and tingling, left greater than right; weakness of the left leg; pain aggravated by activities of daily living), objective findings (antalgic gait; pain with heel walking, greater on the left; tenderness to palpation over the lower lumbar spine with paravertebral spasms; sciatic notch tenderness; decreased range of motion of the lumbar spine; positive straight leg raise on the left; slightly decreased sensation to pinprick and light touch at the L5 and S1 dermatomes bilaterally; motor strength is decreased in all the represented muscle groups in the bilateral lower extremities), and current diagnoses (lower back pain; lumbar spine herniated nucleus pulposus; lower extremity radiculitis). The treating physician has not documented objective evidence of derived functional improvement from completed chiropractic sessions such as improvements in activities of daily living, reduced work restrictions or reduced medical treatment dependence. The criteria noted above not having been met, chiropractic treatment 3 times a week for 6 weeks is not medically necessary.

Aqua therapy 3 times a week for 6 weeks: Upheld

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

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

Decision rationale: The requested aqua therapy 3 times a week for 6 weeks is not medically necessary. Chronic Pain Medical Treatment Guidelines, Aquatic Therapy, Page 22, note that 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 treating physician has documented subjective complaints (burning, radicular lower back pain and muscle spasms; pain rated at a level of 5 out of 10; pain travels down both legs, associated with numbness and tingling, left greater than right; weakness of the left leg; pain aggravated by activities of daily living), objective findings (antalgic gait; pain with heel walking, greater on the left; tenderness to palpation over the lower lumbar spine with paravertebral spasms; sciatic notch tenderness; decreased range of motion of the lumbar spine; positive straight leg raise on the left; slightly decreased sensation to pinprick

and light touch at the L5 and S1 dermatomes bilaterally; motor strength is decreased in all the represented muscle groups in the bilateral lower extremities), and current diagnoses (lower back pain; lumbar spine herniated nucleus pulposus; lower extremity radiculitis). The treating physician has not documented failed land-based therapy or the patient's inability to tolerate a gravity-resisted therapy program. The treating physician has not documented objective evidence of derived functional benefit from completed aquatic therapy sessions, such as improvements in activities of daily living or reduced work restrictions or decreased reliance on medical intervention. The criteria noted above not having been met, aqua therapy 3 times a week for 6 weeks is not medically necessary.