

Case Number:	CM15-0168742		
Date Assigned:	09/15/2015	Date of Injury:	04/10/2014
Decision Date:	10/14/2015	UR Denial Date:	08/06/2015
Priority:	Standard	Application Received:	08/27/2015

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: Physical Medicine & Rehabilitation

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 sustained an industrial injury on 4-10-2014. She reported pain in the neck, low and mid back from pulling and lifting activity. Diagnoses include lumbago, chronic pain syndrome, and thoracic or lumbosacral neuritis or radiculitis. Treatments to date include activity modification, medication therapy, physical therapy, chiropractic therapy, and epidural steroid injection. Currently, she complained of ongoing low back pain rated 7 out of 10 VAS with radiation to the right leg. She was noted to complete eight of eight physical therapy sessions, although one exercise was noted to increase pain, she discontinued that exercise and reported still wanting additional sessions. Current medications included trazodone and Tylenol. On 7-16-15, the physical examination documented limited lumbar range of motion with tenderness in the muscles and on the spinous process. The lumbar facet loading and straight leg raise were positive. The plan of care included additional chiropractic therapy. It was noted sixteen sessions were completed with benefit noting specifically increased range of motion and improvement in flexibility and strength. The appeal requested an additional eight (8) chiropractic therapy sessions, once a week for eight weeks and a cane for ambulation. The Utilization Review dated 8-6-15, denied the request stating that the documentation did not support medical necessity per CA MTUS Guidelines and Official Disability Guidelines.

IMR ISSUES, DECISIONS AND RATIONALES

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

Continued Chiropractic Sessions (Lumbar) Once per Week for 8 Weeks: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Manual therapy & manipulation.

Decision rationale: MTUS Guidelines supports chiropractic manipulation for musculoskeletal injury with continued recommendation upon identified improvements. It appears the patient has received at least 16 sessions. Submitted reports have not demonstrated clear specific functional benefit or change in chronic symptoms and clinical findings for this chronic April 2014 injury. Although the provider reported benefit noted, there are unchanged clinical findings and functional improvement in terms of decreased pharmacological dosing with pain relief, decreased medical utilization, increased ADL or improved work/functional status from treatment already rendered by previous chiropractic care. Clinical exam remains unchanged without acute flare-up or new red-flag findings. It appears the patient has received an extensive conservative treatment and should have the knowledge to perform an independent exercise program; however, no functional restoration approach is noted. The Continued Chiropractic Sessions (Lumbar) Once per Week for 8 Weeks is not medically necessary and appropriate.

Cane: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines - TWC Knee & Leg Procedure Summary, Online Version, Walking Aids.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Walking aids (canes, crutches, braces, orthoses, & walkers), page 358-359.

Decision rationale: Review indicates the patient has normal gait and balance without use of assistive device. Per Guidelines, disability, pain, and age-related impairments seem to determine the need for a walking aid; however, medical necessity for request of this walking aid has not been established as no specific limitations in ADLs have been presented. The patient is currently taking medications for the chronic pain complaints. The provider noted the patient is ambulating without assistive devices and without documented difficulties or specific neurological deficits defined that would hinder any ADLs. Exam had no findings of correlating progressive neurological deficits in motor strength and sensation in the lower extremities nor is there any recent acute injury or surgical procedure requiring an assistive device. The patient has been participating in outpatient office visits without issues and does not appear to be home bound. Submitted reports have not demonstrated adequate support for this from a clinical perspective without new acute injury or red-flag conditions. The Cane is not medically necessary and appropriate.

