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| Case Number: | CM15-0185636 | | |
| Date Assigned: | 09/25/2015 | Date of Injury: | 07/19/2014 |
| Decision Date: | 11/02/2015 | UR Denial Date: | 09/08/2015 |
| Priority: | Standard | Application Received: | 09/21/2015 |

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 38 year old female, who sustained an industrial injury on 7-19-14. She is diagnosed with lumbar strain-sprain, lumbar degenerative disc disease, lumbar spondylosis and sacroiliitis. Her work status is temporary modified duty. A note dated 9-2-15 reveals the injured worker presented with complaints of "central lumbosacral pain (right greater), lumbar, legs, front thighs to feet" rated at 7 out of 10. She also reports swelling in her hands and feet. She reports needing assistance with donning her shoes and socks. A physical examination, of the lumbar spine, dated 9-2-15 revealed dull to light touch of the bilateral anterior thighs in a non-dermatomal fashion. She is tender to palpation at L4-L5 and L5-S1 and S1 joints. Her motion is extremely guarded due to the pain. Her reflexes are equal and symmetric bilaterally. Strength testing is difficult to assess due to pain. Her lumbar spine range of motion is as follows; flexion 30 degrees, extension 10 degrees, left lateral bend 10 degrees and right lateral bend 10 degrees. A lumbar spine examination dated 7-8-15 reveals referred pain (right greater than left) of the anterior thigh with a straight leg raise at 90 degrees. Her motor strength is 5 out of 5. She has moderate pain over the L4-L5 and L5-S1 region (right greater than left). Her lumbar spine range of motion is; forward flexion 50 degrees, extension 35 degrees, bilateral lateral flexion 45 degrees and bilateral rotation 35 degrees all with moderate pain (rotation has right side referred pain). Treatment to date has included the medications Amitriptyline and Lidoderm patches. Physical therapy (approximately 16 sessions) provided slight efficacy in pain levels, function and range of motion, per note dated 9-2-15. Diagnostic studies to date have included an MRI (2014). A request for authorization dated 9-4-15 for chiropractic treatment x 6 sessions and

electromyography (EMG) of the bilateral lower extremities is denied, per Utilization Review letter dated 9-8-15.

IMR ISSUES, DECISIONS AND RATIONALES

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

Outpatient Chiropractic Treatment x 6 Sessions: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines; Pain. 1997 May; 71 (1): 5-23. An assessment of the efficacy of physical therapy and physical modalities for the control of chronic musculoskeletal pain.

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. The intended goal is the achievement of positive musculoskeletal conditions via positive symptomatic or objective measurable gains in functional improvement that facilitate progression in the patient's therapeutic exercise program and return to productive activities. It is unclear how many sessions have been completed to date. Submitted reports have not demonstrated clear specific functional benefit or change in chronic symptoms and clinical findings for this chronic injury. There are unchanged clinical findings and functional improvement in terms of decreased pharmacological dosing with pain relief, decreased medical utilization, increased ADLs or improved functional status from previous chiropractic treatment already rendered. Clinical exam remains unchanged without acute flare-up, new red-flag findings, or new clinical findings to support continued treatment consistent with guidelines criteria. It appears the patient has received an extensive conservative therapy treatment trial; however, remains not changed without functional restoration approach. The Outpatient Chiropractic Treatment x 6 Sessions is not medically necessary and appropriate.

Outpatient Electromyography (EMG) of the Bilateral Lower Extremities: Upheld

Claims Administrator guideline: Decision based on MTUS Low Back Complaints 2004.

MAXIMUS guideline: Decision based on MTUS Low Back Complaints 2004, Section(s): Special Studies.

Decision rationale: There were no correlating neurological deficits defined or conclusive imaging identifying possible neurological compromise. Per MTUS Guidelines, without specific symptoms or neurological compromise consistent with radiculopathy, foraminal or spinal stenosis, and entrapment neuropathy, medical necessity for EMG and NCV has not been established. Submitted reports have not demonstrated any symptoms or correlating myotomal/dermatomal clinical findings to suggest any lumbar radiculopathy or entrapment syndrome with intact motor strength, DTRs, and diffuse dull sensation in a non-dermatomal pattern. The Outpatient Electromyography (EMG) of the Bilateral Lower Extremities is not medically necessary and appropriate.

