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| Case Number: | CM15-0040340 | | |
| Date Assigned: | 03/10/2015 | Date of Injury: | 07/09/2003 |
| Decision Date: | 04/17/2015 | UR Denial Date: | 02/16/2015 |
| Priority: | Standard | Application Received: | 03/03/2015 |

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: New York, Tennessee
 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:

The injured worker is a 67-year-old female, who sustained an industrial injury on 07/09/2003. Initial complaints reported included injury to the right knee, right wrist and low back resulting from a fall from a stool. The initial diagnoses were not provided. Treatment to date has included conservative care, medications, physical therapy, chiropractic manipulation, bilateral knee surgeries, injections, radiographic imaging, and MRI imaging. Currently, the injured worker complains of flare-up of low back symptoms consisting of peri-articular degeneration in the lumbosacral segments. There are also noted reports of this condition being stable. Current diagnoses include lumbar strain/sprain, and degenerative joint disease-post surgical knee. The treatment plan was to include continued chiropractic physical therapy, medications (by in-house physician), and follow up.

IMR ISSUES, DECISIONS AND RATIONALES

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

Chiropractic Physical Therapy One to Three Visits for a Two Week Period, Lower Back, Bilateral Knee, QTY: 6: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Pain Interventions and Guidelines Page(s): 58.

Decision rationale: Manual therapy and evaluation are 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. Recommended treatment parameters are as follows: Time to produce effect: 4-6 treatments, frequency of 1-2 times per week with maximum duration of 8 weeks. In this case, the patient has prior chiropractic treatment. There is no documented objective evidence of functional improvement. In addition, the requested frequency of 1-3 treatments weekly surpasses the recommended frequency of 1-2 times weekly. The request should not be authorized.