

Case Number:	CM14-0144495		
Date Assigned:	09/12/2014	Date of Injury:	11/07/2010
Decision Date:	10/16/2014	UR Denial Date:	09/02/2014
Priority:	Standard	Application Received:	09/05/2014

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. The expert reviewer is Board Certified in Physical Medicine & Rehabilitation, has a subspecialty in Pain Medicine and is licensed to practice in Texas and Ohio. 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

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 male who reported an injury on 11/07/2010 due to having a chicken package that weighed 11 pounds and reaching overhead, injured his back. The injured worker complained of mid to lower back pain with a diagnosis of thoracolumbar sprain/strain and lumbosacral sprain/strain. The diagnostics include neurodiagnostic studies dated 03/20/2014 that revealed lumbosacral spine with flexion extension views was unremarkable and demonstrated no evidence of instability. The physical examination of the lumbar spine dated 03/25/2014 revealed a flexion of 60 degrees and extension alkalosis 0 degrees. No tenderness about the chest or sternum bilaterally, normal range of motion with the thoracic spine in all directions. No tenderness to the paraspinal muscles at the thoracic region. The lumbosacral spine revealed no tenderness or paraspinal muscle spasms at the lumbosacral region forward flexion 60 degrees and extension 25 degrees, a negative Braggart's test, negative Lasegue's test, negative flip test, and a negative Fajersztajn's test, neurological examination revealed 5/5 motor strength to the upper and lower extremities, the sensation intact to pinprick and light touch to all dermatomes of the upper and lower extremities. No medications noted. The request for authorization dated 09/12/2014 was submitted with documentation.

IMR ISSUES, DECISIONS AND RATIONALES

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

Chiropractic 4 sessions , 1x4 thoracic spine: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical medicine Chiropractic, Physical Medicine Page(s): 58.

Decision rationale: The request for Chiropractic 4 sessions, 1x4 thoracic spine is not medically necessary. The California MTUS Guidelines state that chiropractic care for chronic pain that is caused by musculoskeletal conditions is recommended. The intended goal or effect of manual medicine is the achievement of positive symptomatic or objective measurable gains in functional improvement to facilitate progression of the patient's therapeutic exercise program and return to productive activities. The clinical notes indicate that the injured worker had prior chiropractic therapy; however, no number of visits or the functional outcome. The clinical notes also indicate physical findings of normal findings other than the injured worker's subjective complaints, no objective findings correlated with the subjective complaints. No medications noted. No measurable function of pain noted. As such, the request is not medically necessary.

Therapeutic Exercise and manual therapy 4 sessions 1 x4 thoracic spine: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine, Page(s): 58.

Decision rationale: The request for Therapeutic Exercise and manual therapy 4 sessions 1 x4 thoracic spine is not medically necessary. The California MTUS Guidelines state that chiropractic care for chronic pain that is caused by musculoskeletal conditions is recommended. The intended goal or effect of manual medicine is the achievement of positive symptomatic or objective measurable gains in functional improvement to facilitate progression of the patient's therapeutic exercise program and return to productive activities. The clinical notes indicate that the injured worker had prior chiropractic therapy; however, no number of visits or the functional outcome. The clinical notes also indicate physical findings of normal findings other than the injured worker's subjective complaints, no objective findings correlated with the subjective complaints. No medications noted. No measurable function of pain noted. As such, the request is not medically necessary.

Physiotherapy rehabilitation: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Page(s): 98.

Decision rationale: The request for Physiotherapy rehabilitation is not medically necessary. The California MTUS Guidelines state that active therapy is based on the philosophy that therapeutic exercise and/or activity are beneficial for restoring flexibility, strength, endurance, function, range of motion, and alleviate discomfort. Active therapy requires an internal effort by the individual to complete a specific exercise or task. Injured workers are instructed and expected to continue active therapies at home as extension of the treatment process in order to maintain improvement levels. There was a lack of documentation indicating that the injured worker had any physical findings to warrant therapy. The injured worker indicated that the TENS unit that was alleviating pain. No objective or functional measurements indicating pain level. The injured worker is doing a home exercise program. As such, the request is not medically necessary.

Pain management evaluation: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM. Decision based on Non-MTUS Citation Official Disability Guideline (ODG) TWC, Pain Procedure

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG Pain, Office Visit

Decision rationale: The request for Pain management evaluation is not medically necessary. The California MTUS/ACOEM Guidelines do not address. The Official Disability Guidelines recommend office visits for proper diagnosis and return to function of the injured worker. The need for a clinical office visit with a health care provider is individualized based upon a review of the patient's concerns, signs and symptoms, clinical stability, and reasonable physician judgment. As the patient's conditions are extremely varied, a set number of office visits per condition cannot be reasonably established. The determination of necessity for an office visit requires individualized case review and assessment, being ever mindful the best patient outcomes are achieved with the eventual patient independence from the healthcare system through self-care as soon as clinically feasible. The clinician notes the physical findings to not warrant any pain management evaluation. The clinical notes also lacked the documentation of a measurable pain function. As such, the request is not medically necessary.