

Case Number:	CM13-0063929		
Date Assigned:	01/03/2014	Date of Injury:	04/26/2003
Decision Date:	04/07/2015	UR Denial Date:	11/22/2013
Priority:	Standard	Application Received:	12/11/2013

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: Ohio, North Carolina, Virginia
 Certification(s)/Specialty: Family Practice

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 61 year old female, who sustained an industrial injury on April 26, 2003. She reported a pop in her low back and significant pain. Her diagnoses include chronic low back pain, lumbar radiculopathy, status post lumbar fusion, status post hardware removal in 2006, mild to moderate disc space narrowing lumbar 5-sacral 1, spondylolisthesis lumbar 3-4, multilevel degenerative lumbar disc disease, lumbar 3-4 stenosis, multilevel bilateral lumbar neural foraminal narrowing, and lumbar spine facet arthropathy. She has been treated with electrodiagnostic studies on June 6, 2013, an MRI on July 30, 2013, a home exercise program, work modifications, lumbar epidural steroid injections, acupuncture, lumbar support, and medications including oral and topical pain, and a muscle relaxant. The records refer to a prior course of chiropractic therapy, but do not provide specific dates or result. The agreed medical evaluator noted on July 30, 2013, that prior chiropractic therapy did not provide significant benefit. On September 11, 2013, her treating physician reports worsening pain with stabbing, numbness, and tingling in her right lower extremity all the way to the foot. The physical exam from September 9, 2013 revealed a mild antalgic gait and normal heel and toe walk with pain on the right side. There was tenderness to palpation over the paralumbar musculature more on the right, decreased range of motion, decreased sensation to the right lumbar 5 and sacral 1 dermatome, and normal motor strength, except for the right psoas was mildly decreased. The bilateral patellar and Achilles were hyperreflexic, positive right straight leg raise at 60 degrees with symptoms radiating to her toes, negative clonus, positive right slump test, and positive right Lasegue's. The treatment plan includes a microlumbar decompression at the right lumbar 5-

sacral 1. On November 22, 2013, Utilization Review non-certified a prescription for an additional 12 visits (2 times a week for 6 weeks) of postoperative chiropractic/physical therapy, noting the surgery for this case was not certified. The California Medical Treatment Utilization Schedule (MTUS) was cited.

IMR ISSUES, DECISIONS AND RATIONALES

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

Post Operative Chiro/Physiotherapy (two times a week for six weeks): Upheld

Claims Administrator guideline: Decision based on MTUS Postsurgical Treatment Guidelines.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back Chapter, Manipulation and Physical Therapy.

Decision rationale: The injured worker had lumbar fusion surgery in 2003 and hardware removal in 2006. She has been under consideration for a microlumbar decompression at L5-S1 but as of the last dated medical from 11-22-2013 surgery had been denied. The requested service is for post operative chiro/physiotherapy. The guidelines for chiropractic and physical therapy are listed below. ODG Chiropractic Guidelines (for manipulation): Therapeutic care: Mild: up to 6 visits over 2 weeks Severe: Trial of 6 visits over 2 weeks Severe: With evidence of objective functional improvement, total of up to 18 visits over 6-8 weeks, if acute, avoid chronicity Elective/maintenance care : Not medically necessary Recurrences/flare-ups: Need to re-evaluate treatment success, if RTW achieved then 1-2 visits every 4-6 months when there is evidence of significant functional limitations on exam that are likely to respond to repeat chiropractic care Severe may include severe sprains/strains (Grade II-III) and/or non-progressive radiculopathy (the ODG Chiropractic Guidelines are the same for sprains and disc disorders). In terms of physical therapy, the guidelines allow for Post-surgical treatment (discectomy/laminectomy): 16 visits over 8 weeks. In this instance, this request appears to be two requests in one. There appears to be a request for 12 sessions each of chiropractic care and physical therapy post-operatively. As of the last dated note, 11-22-2013. the proposed surgery was still denied. The manipulation guidelines allow for an initial trial of 6 chiropractic visits and up to 18 visits with evidence of functional improvement after the initial trial. It is unclear if the treating physician meant the request to mean post-operative chiropractic care and physical therapy, or merely physical therapy. in any event, the request is not sufficiently clear to establish medical necessity.