

Case Number:	CM15-0113879		
Date Assigned:	06/22/2015	Date of Injury:	06/09/2014
Decision Date:	07/21/2015	UR Denial Date:	05/20/2015
Priority:	Standard	Application Received:	06/12/2015

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, Indiana, New York
Certification(s)/Specialty: Internal 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 61 year old female injured worker suffered an industrial injury on 06/09/2014. The diagnoses included lumbago, sciatica, lumbar radiculitis, lumbar herniated disc lumbosacral spinal stenosis, lumbar facet arthropathy, headaches, cervical disc protrusion, myospasms, sprain/strain, thoracic muscle spasms and sprain/strain and right/left knee internal derangement. The diagnostics included lumbar, right knee, magnetic resonance imaging and electromyographic studies/nerve conduction velocity studies. The injured worker had been treated with On 4/7/2015 the treating provider reported increased headaches, cervical spine constant moderate pain 8/10, thoracic spine 6/10 upper/mid back pain and lumbar spine pain rated 10/10 with numbness and tingling. The right knee pain was 9/10 and left knee pain 7/10 with numbness and tingling. There was tenderness to the lumbar and thoracic spine with reduced range of motion. The treatment plan included Chiropractic care and Range of Motion (ROM) test.

IMR ISSUES, DECISIONS AND RATIONALES

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

Chiropractic care, 2 times a week for 4 weeks: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Chiropractic therapy Page(s): 58-60. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain section, Chiropractic therapy.

Decision rationale: Pursuant to the Chronic Pain Medical Treatment Guidelines and the Official Disability Guidelines, chiropractic sessions two times per week times four weeks are not medically necessary. Manual manipulation and therapy is recommended for chronic pain is caused by musculoskeletal conditions. The intended goal or effective manual medicine is the achievement of positive symptomatic or objective measurable gains and functional improvement. Manipulation, therapeutic care-trial of 6 visits over two weeks. With evidence of objective functional improvement, total of up to 18 visits over 6 to 8 weeks. Elective/maintenance care is not medically necessary. In this case, the injured worker's working diagnoses are dizziness, headache, cervical disc protrusion, cervical myospasm, cervical sprain strain, thoracic spasm, thoracic sprain strain, lumbar disc protrusion, lumbar myospasm, lumbar pain, lumbar radiculopathy, lumbar sprain strain, right knee pain, right knee sprain strain, left knee pain, and left knee sprain strain. Utilization review indicates the injured worker received prior chiropractic treatment. According to the April 7, 2015 progress note, your work or has multiple complaints of memory difficulty dizziness and headaches, neck pain, upper and lower back pain right and left knee pain. Objectively, there is tenderness to palpation over the cervical thoracic and paraspinal muscle. The treatment plan state chiropractic two visits per week times four weeks to increase range of motion, and increase activities of daily living and decreased pain is indicated. The treating provider does not indicate what anatomical region is to be treated. Additionally, it is unclear whether the injured worker received prior chiropractic manipulation. The guidelines allow a therapeutic trial of six visits over two weeks. If the injured worker has not received prior chiropractic treatment, a six visit clinical trial is indicated. The treating provider requested eight sessions of chiropractic treatment. If the injured worker received prior chiropractic treatment, documentation would need to provide objective functional improvement for additional chiropractic treatment to be considered. Consequently, absent clinical documentation with a specific anatomical area to be treated in an injured worker with multiple complaints, evidence of prior chiropractic treatment (if received), a chiropractic request in excess of the recommended guidelines and a clinical rationale with therapeutic gains to be achieved with chiropractic manipulation, chiropractic sessions two times per week times four weeks are not medically necessary.

Range of Motion (ROM) test (undefined): Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guideline (ODG), Computerized ROM studies.

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 section, Range of motion.

Decision rationale: Pursuant to the Official Disability Guidelines, Range of Motion (ROM) test (undefined) is not medically necessary. Computerized range of motion (flexibility) is not recommended as a primary criterion, but should be part of a routine musculoskeletal evaluation. The relation between lumbar range of motion measures and functional abilities were nonexistent. This has implications for clinical practice as it relates to disability determinations for patients with chronic low back pain. In this case, the injured worker's working diagnoses are for range of motion testing over and above that performed during a routine physical examination dizziness, headache, cervical disc protrusion, cervical myospasm, cervical sprain strain, thoracic spasm, thoracic sprain strain, lumbar disc protrusion, lumbar myospasm, lumbar pain, lumbar radiculopathy, lumbar sprain strain, right knee pain, right knee sprain strain, left knee pain, and left knee sprain strain. Utilization review indicates the injured worker received prior chiropractic treatment. According to the April 7, 2015 progress note, your work or has multiple complaints of memory difficulty dizziness and headaches, neck pain, upper and lower back pain right and left knee pain. Objectively, there is tenderness to palpation over the cervical thoracic and paraspinal muscle. Computerized range of motion (flexibility) is not recommended as a primary criterion, but should be part of a routine musculoskeletal evaluation. The relation between lumbar range of motion measures and functional abilities were nonexistent. There is no clinical indication or rationale for range of motion testing over and above that performed during the routine physical examination. Based on the clinical information in the medical record and the peer-reviewed evidence-based guidelines, Range of Motion (ROM) test (undefined) is not medically necessary.