

Case Number:	CM15-0071687		
Date Assigned:	04/21/2015	Date of Injury:	07/02/2013
Decision Date:	05/20/2015	UR Denial Date:	03/10/2015
Priority:	Standard	Application Received:	04/14/2015

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: Preventive Medicine, Occupational 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 38-year-old male who sustained an industrial injury on 7/2/2013. His diagnoses, and/or impressions, included lumbar and thoracic herniated nucleus pulposus with moderate neural foraminal narrowing and moderate central canal stenosis; severe lumbar radiculopathy; and worsening left shoulder arthralgia. Recent magnetic resonance imaging studies of the left shoulder was noted to be done on 1/27/2015; previous magnetic resonance imaging studies of the lumbar spine was said to have been done on 4/9/2014, and the thoracic spine on 3/31/2014. Electromyogram of the bilateral lower extremities was stated to have been done on 7/24/2014. His treatments have included chiropractic treatments; physical therapy; acupuncture treatments; a qualified medical evaluation on 11/10/2014; modified work duties; and medication management. Progress notes of 2/10/2015 reported constant, moderate, achy low back pain, and intermittent, mild, achy left shoulder pain. The physician's requests for treatments were noted to include bilateral micro-lumbar decompression surgery with pre-operative laboratories, chest x-ray, electrocardiogram and urology consultation, with post-operative pain management and chiropractic treatments.

IMR ISSUES, DECISIONS AND RATIONALES

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

Urology consultation: Overturned

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation American College of Occupational and Environmental Medicine, Chapter 7, page 127.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 5 Cornerstones of Disability Prevention and Management Page(s): 78, 79, 90.

Decision rationale: Per the MTUS Guidelines, the clinician acts as the primary case manager. The clinician provides medical evaluation and treatment and adheres to a conservative evidence-based treatment approach that limits excessive physical medicine usage and referral. The clinician should judiciously refer to specialists who will support functional recovery as well as provide expert medical recommendations. Referrals may be appropriate if the provider is uncomfortable with the line of inquiry, with treating a particular cause of delayed recovery, or has difficulty obtaining information or agreement to a treatment plan. The requesting physician explains that the injured worker has history of loss of bladder control at night and has been directed to the ER. The requesting physician is unable to explain the injured worker's incontinence based on MRI of the spine. This request is for urology to evaluate the injured workers; Incontinence and determine if there is an industrial basis. Medical necessity for urology consultation is determined to be medically necessary.

Post operative chiropractic for the lumbar spine, twice a week for six weeks: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Manual Therapy and Manipulation Page(s): 58.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Manual Therapy & Manipulation Page(s): 58-61.

Decision rationale: Per the MTUS Guidelines, chiropractic care consisting of manual therapy and manipulation for the low back is 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 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. A therapeutic trial of 6 visits over 2 weeks is recommended. If there is evidence of objective functional improvement, a total of up to 18 visits over 6 to 8 weeks is recommended. Elective or maintenance care is not recommended. Recurrences or flare-ups should be evaluated for treatment success, and if return to work is achieved, 1-2 visits every 4-6 months are reasonable. This request exceeds the number of chiropractic visits recommended by the MTUS Guidelines. The request for postoperative chiropractic care for the lumbar spine twice a week for six weeks is determined to not be medically necessary.