

Case Number:	CM13-0025261		
Date Assigned:	01/10/2014	Date of Injury:	11/30/2011
Decision Date:	06/25/2014	UR Denial Date:	08/26/2013
Priority:	Standard	Application Received:	09/16/2013

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. The expert reviewer is licensed as a Chiropractor and is licensed to practice in Texas. 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 61-year-old male with a reported injury date of November 30, 2011; a mechanism of injury was not provided. The clinical note dated June 24, 2013 noted that the injured worker had complaints of persistent low back pain and left knee pain. It was also noted that the injured worker stated the pain was well controlled with medication. Examination of the lumbar spine noted tenderness to the right sacroiliac region, limited range of motion of the lumbar spine secondary to pain, and a positive sitting root test. It was also noted that sensation was intact to lower bilateral extremities. Examination of the left knee noted tenderness to the left infrapatellar and left medial knee. The treatment plan noted that the physician was going to request chiropractic treatment which included supervised physical therapy at 2 visits. The injured worker's diagnoses include lumbar spine disc protrusion with radiculopathy, left knee medial meniscal tear, and left knee infusion. The Request for Authorization Form for chiropractic therapy 2 times a week times 6 weeks for the lumbar spine was not provided within the available documentation.

IMR ISSUES, DECISIONS AND RATIONALES

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

CHIROPRACTIC THERAPY 2 TIMES A WEEK TIMES 6 WEEKS, LUMBAR: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation MTUS: CHRONIC PAIN MEDICAL TREATMENT GUIDELINES, MANUAL THERAPY AND MANIPULATION, 58-59

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

Decision rationale: The California MTUS Guidelines state that manual therapy may be recommended for chronic pain if caused by musculoskeletal conditions. The intended goal or effect of manual medicine is the achievement of positive sympathetic or objective measurable goals of functional improvement that facilitate progression in the patient's therapeutic exercise program and return to productive activities. The guidelines also state that a trial of 6 visits over 2 weeks may be warranted and if there is evidence of objective functional improvement then a total of up to 18 visits over 6 to 8 weeks may be recommended. There is a lack of evidence provided within the available documentation that the injured worker will be participating in a therapeutic exercise program in conjunction with this requested service. Additionally, there was a lack of documentation provided addressing the rationale for this requested treatment. Furthermore, the request exceeds the recommendation of a trial of 6 visits over 2 weeks. As such, this request is not medically necessary.