

Case Number:	CM13-0038340		
Date Assigned:	12/18/2013	Date of Injury:	08/14/2012
Decision Date:	03/12/2014	UR Denial Date:	09/27/2013
Priority:	Standard	Application Received:	10/25/2013

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 in Chiropractic Treatment and is licensed to practice in California. 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 patient is a 42-year-old female who was injured at work on 8/14/12. The patient injured her right hip and lower back as a direct result from a slip and fall. The patient has been treated with a course of physical therapy, trigger point injections, chiropractic treatment and medications. The patient had electromyography/nerve conduction velocity (EMG/NCV) studies of the lower extremity. The MRI of the lumbar spine performed on 11/08/12 identifies multilevel mild disc disease with annular tears, but no reports of central canal, lateral recess or neural foraminal stenosis: and no evidence of facet arthropathy. The MRI of the lumbar spine with flex-ext performed on 08-10-2013, showed an impression of L1-2: focal central disc protrusion with annular tear effacing the thecal sac, L2-3 diffuse disc protrusion with effacement of the thecal sac, L3-4 diffuse disc protrusion with effacement of the thecal sac, L4-5 diffuse disc protrusion with effacement of the thecal sac, bilateral stenosis of neuroforamina that effaces the left and encroaches the right L4 exiting nerve root, and L5-S1 diffuse disc protrusion without effacement of the thecal sac. The MRI also showed narrowing of the left neural foramen that effaces the left L5 exiting nerve root. Clinical notes indicate that the patient complained about the right knee, right hip and lower back. An examination note of the lumbar spine revealed a positive straight leg raise at 70° from the seated position, positive lasague sign. There was also no motor weakness on L3 through S1. There was deep tendon tenderness to palpation L4 - 5 and L5-S1, as well as over the lumbar facet joints bilaterally at L4-5 and L5 - S1. The pain is getting worse, and a right hip examination revealed pain with internal rotation and limited internal rotation. External rotation indicated that there was no discomfort. Hip flexion was slightly limited. Diagnoses included lumbar discogenic disease, an annular tear at L4-5 and L5- S1 per MRI findings, right hip sprain/string superimpose upon coccidiodal deformity and significant

osteoarthritic changes of that right hip. The patient's physician is requesting chiropractic treatment twice weekly for six weeks.

IMR ISSUES, DECISIONS AND RATIONALES

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

request for chiropractic treatment for the lumbar spine and right hip, twice a week for six (6) weeks per the 09/03/2013 report QTY: 12.00: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): s 58-59.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Manual therapy and manipulation Page(s): s 58-59.

Decision rationale: The Chronic Pain Guidelines indicate that manual therapy and manipulation is recommended for chronic pain if it is caused by musculoskeletal conditions. It is recommended as a therapeutic trial of six (6) visits over two (2) weeks, with evidence of objective functional improvement. The frequency recommended by the guidelines is one to two (1-2) times per week for the first two (2) weeks, as indicated by the severity of the condition. Treatment may be continued at one (1) treatment per week for the next six (6) weeks. There should be some outward sign of subjective or objective improvement within the first six (6) visits. In this case, there is no documentation of objective evidence of any functional improvement with the most recent course of chiropractic treatment provided. The current request exceeds the guidelines recommended treatment. Therefore, the request is non-certified.