

Case Number:	CM13-0048995		
Date Assigned:	12/27/2013	Date of Injury:	01/09/2000
Decision Date:	05/12/2014	UR Denial Date:	10/30/2013
Priority:	Standard	Application Received:	11/07/2013

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 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 biomechanics of the original injury: The claimant was working as a houseman and was injured while walking down a wet area and slipped and fell injuring his right hip on 1/9/2000. The claimant is currently 14 years, 3 months post injury. A PR2 dated 10/16/13 by the treating physician noted subjective complaints of lumbar spine pain rated 7/10, radiating to both legs with numbness as well as right ankle pain. Objective signs of tenderness to the lumbar spine. Positive SLR. Bilateral tenderness noted in the lumbar spine. Treatment to date has included the following: Lumbar spine surgery an arthrodesis fixation with screws at L4/5 on Feb. 2001 with [REDACTED] Post op PT. Claimant has had extensive chiropractic care to date: On 9/26/11 the patient had 6 visits of chiropractic care. On 10/5/11 an additional 12 visits of chiropractic were certified. 9/5/13 Peer Review Determination. Significant testing or imaging: MRI of the lumbar spine. Pre-surgical MRI of the lumbar spine revealed a 4 mm disc herniation at L4/5. Electrodiagnostic study of the lower extremity on Nov. 2, 2011 by [REDACTED], [REDACTED] Impression this is an abnormal study suggestive of a left L5 radiculopathy. CT of the lumbar spine was performed 10/3/2011. EMG/NCV of the lower extremities was performed on 7/31/2013 with abnormal findings. Requested services: The current request is for Chiropractic treatments 2 x 4 weeks. On 10/30/13 a pre-auth request for Chiropractic care 2 x 4 weeks was non-certified. This is the request which has been submitted for IMR at this time.

IMR ISSUES, DECISIONS AND RATIONALES

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

CHIROPRACTIC TREATMENT 2X4 WEEKS: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines MANUAL THERAPY AND MANIPULATION,.

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

Decision rationale: The CA MTUS Chronic Pain Medical Treatment Guidelines, Manual Therapy & Manipulation, Page 58 to 60, states, CA MTUS 2009 (Effective July 18, 2009) - Chronic Pain Medical Treatment Guidelines, states, Manual therapy & manipulation - 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 of Manual Medicine 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. Manipulation is manual therapy that moves a joint beyond the physiologic range-of-motion but not beyond the anatomic range-of-motion. Low back: Recommended as an option. Therapeutic care - Trial of 6 visits over 2 weeks, with evidence of objective functional improvement, total of up to 18 visits over 6-8 weeks. 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. The claimant has already been authorized or certified for at least 18 visits of chiropractic treatments which have already been provided with out evidence of objective functional improvements. The current request exceeds the max number of recommended and allowed chiropractic visits for this work injury with out evidence of prior treatment efficacy or objective functional improvements which is required for continued care or treatments or even treatments on a flare up basis. The current request is not consistent with the evidence based guideliines. Protracted passive therapy with out documented gains creates dependency. The current request is not consistent with the evidence based guidelines.