MAXIMUS Federal Services

Case Number:	CM13-0061434		
Date Assigned:	12/30/2013	Date of Injury:	12/10/2010
Decision Date:	10/22/2014	UR Denial Date:	11/21/2013
Priority:	Standard	Application Received:	12/04/2013

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 Care, has a subspecialty in Acupuncture and is licensed to practice in New York. 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:

Upon review of the medical records provided the applicant was a 41 year old male whom sustained a work related injury that occurred on December 10, 2010 when he twisted his right knee from stepping onto a ladder while employed by [redacted]. Thus far, the applicant was diagnosed with failed right knee surgery, left knee internal derangement, left elbow lateral humeral epicondyle, lumbar spine disc bulge. He underwent Extracorporeal shockwave treatment ot the lumbar spine. Upon review of a PR-2 report dated 11/11/13 treatment plan the applicant presetned with lower back pain as well as bilateral knee pain. A request for chiropractic treatment one time per week for six weeks was prescribed as well as right knee arthroscopy and left knee injections. There was no examination demonstrated with regards to the lumbar spine. A diagnosis was given as: lumbar spine disc bulge. Right anterior thigh, right lateral ankle and lateral calf light touch sensation was intact.Upon review of a PR-2 examination report dated 7/8/13 the lumbar examination consisted of reduced lumbar ranges of motion.In a utilization review report dated 11/21/13, the reviewer determined the proposed 6 chiropractic treatments to the lumbar spine was not medically necessary and non-certified as well as guideline criteria was not met. The reviewer indicated that no recent specific deficits for the lumbar spine has been documented and recent progress notes were handwritten and illegible.

IMR ISSUES, DECISIONS AND RATIONALES

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

Chiropractic treatment for the lumbar spine x 6: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines.

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

Decision rationale: The MTUS Chronic Pain Treatment Guidelines indicate treatment may be indicated initially for the lumbar spine in a trial of 6 visits over 2 weeks. Elective therapy is not recommended. For recurrences/flare-ups there is a need to re-evaluate treatment success and if returned to work is achieved then 1-2 visits every 4-6 months. In this case there was no indication of the number of prior chiropractic treatment visits that were received as well as to the clinical response to prior treatment. There were subjective complaints of low back pain without any recent lumbar examination findings or functional objective improvement clinically concerning the lumbar spine. As such, the request is not medically necessary.