

Case Number:	CM14-0007865		
Date Assigned:	02/10/2014	Date of Injury:	05/02/1996
Decision Date:	07/11/2014	UR Denial Date:	01/07/2014
Priority:	Standard	Application Received:	01/17/2014

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 Board Certified in Occupational Medicine 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 62-year-old male who has submitted a claim for lumbago, sacroiliac pain, and muscle spasms associated with an industrial injury date of May 2, 1996. Medical records from 2012-2013 were reviewed. The patient complained of persistent low back pain, grade 3-4/10 in severity. There was associated tightness. Physical examination showed pain at the right ilium and L4 and L5. There was mild degree of edema at L4 and L5 bilaterally. Moderate edema was noted on the right ilium. There was moderate hypertonicity of the gluteal muscles on the right and lumbar paraspinal muscles bilaterally. Treatment to date has included medications, physical therapy, chiropractic therapy, home exercise program, activity modification, Utilization review, dated January 7, 2014, denied the request for chiropractic treatment 2x/month for 24 visits qty: 24 and cold therapy qty: 1 because there was no evidence of recent flare-up, recent loss of functional capacity, a statement as to what prior functional loss was restored by prior treatment, or a statement as to what functional capacity can reasonably be expected to be restored by the requested treatment.

IMR ISSUES, DECISIONS AND RATIONALES

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

CHIROPRACTIC TREATMENT QTY: 24.00: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines MANUAL THERAPY & MANIPULATION Page(s): 58.

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

Decision rationale: CA MTUS Chronic Pain Medical Treatment Guidelines page 58 states that manipulation for the low back is recommended as an option. There should be a trial of 6 visits over 2 weeks, and with evidence of objective functional improvement, total of up to 18 visits over 6-8 weeks. For recurrences/flare-ups, reevaluation of treatment success, if return to work achieved then 1-2 visits every 4-6 months. In this case, the patient previously had an unspecified number of chiropractic therapy sessions since 2012. Although there were descriptions of the chiropractic procedures done, there was no documentation of objective evidence of functional improvement from the sessions. The rationale for the request was to reduce exacerbations to his lower back because of more frequent muscle spasm and pain. However, the said rationale did not reflect with the objective findings from the clinical records submitted. There was no documentation of the said spasms and the pain level remained constant from the recent progress reports. Furthermore, it was not clear whether the previous chiropractic sessions exceeded the recommended total number of visits. The present request would also exceed the guideline recommendations for the number of chiropractic therapy sessions. Therefore, the request for 24 sessions of chiropractic treatment is not medically necessary.

COLD THERAPY QTY: 1.00: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back chapter, Cold/heat packs.

Decision rationale: The CA MTUS does not address this issue specifically. Per the Strength of Evidence hierarchy established by the California Department of Industrial Relations, Division of Workers' Compensation, the Official Disability Guidelines (ODG) was used instead. ODG low back chapter states that cold/hot packs are recommended as an option for acute pain. There is minimal evidence supporting the use of cold therapy. In this case, cold therapy was recommended for the low back region to promote healing by decreasing edema and inflammation in the soft tissues. However, guidelines recommend its use for acute pain and not for edema and inflammation. In addition, it is unclear whether the patient has suffered an acute exacerbation of the back pain since the progress notes indicate that the pain level has been generally steady. Therefore, the request for cold therapy quantity: 1.00 is not medically necessary.