MAXIMUS Federal Services

Case Number:	CM14-0100795		
Date Assigned:	09/16/2014	Date of Injury:	11/05/2001
Decision Date:	10/15/2014	UR Denial Date:	05/30/2014
Priority:	Standard	Application Received:	06/30/2014

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 Licensed in Chiropractic 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 68-year-old who was injured on November 5, 2001. The mechanism of injury is unknown. Progress report dated May 20, 2014 states the patient presented with complaints of severe flare up of his back pain with tightness and soreness. The pain has affected his quality of life such as walking difficulty, decreased sleep, and self-hygiene is challenging. He rated his pain as 9.5/10. He noted medications and wearing a brace provides some relief. Objective findings on exam revealed lumbar spine range of motion is decreased secondary to pain. Straight leg raise is positive at 50 degrees on the left. He has positive sitting root test, left greater than right. Spasms are present and 2+ tenderness of gluteal, piriformis and quadratus lumborum. Deep tendon reflexes are 1+. The patient is diagnosed with lumbar sprain/strain; lumbar intervertebral disc syndrome, and possible right knee internal derangement. He is recommended for chiropractic therapy to the lumbar spine and right knee. Prior utilization review dated May 30, 2014 states the request for Lumbar Spine and Right Knee Chiropractic Treatment 3 x 3 is denied as there is limited documented evidence of functional improvement.

IMR ISSUES, DECISIONS AND RATIONALES

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

Lumbar spine and right knee chiropractic treatment, three times weekly for three 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): 58-59. Decision based on Non-MTUS Citation OFFICIAL DISABILITY GUIDELINES (ODG), LOW BACK, MANIPULATION

Decision rationale: The Chronic Pain Medical Treatment Guidelines states that one to two visits of Chiropractic Care every four to six months is recommended for flair-ups. However there was no documentation found within the records recording of any event having occurred which caused this flair-up for which treatment is being requested. Additinally, review of the patients records fail to adaquately document any measurable improvement in functional capacity having occurred with prior therapy. Regarding Chiropractic treatment to this patient's right knee, The CA MTUS guidelines do no recommendend Chiropractic treatment for the knee. Therefore, the request for Lumbar spine and right knee chiropractic treatment, three times weekly for three weeks, is not medically necessary or appropriate.