

Case Number:	CM14-0107023		
Date Assigned:	08/01/2014	Date of Injury:	12/10/2011
Decision Date:	09/12/2014	UR Denial Date:	06/20/2014
Priority:	Standard	Application Received:	07/10/2014

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 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 on 12/11/2011. The mechanism of injury is unknown. Prior treatment history has included Soma, Xanax, medical marijuana, and Percocet. Progress report dated 07/01/2014 states the patient presented with mid back and low back pain with radiation into the left leg. Her symptoms continue to persist. Objective findings on exam revealed decreased sensation in L5 distribution. She has tenderness to palpation in the upper lumbar region. Straight leg raise is positive with positive FABER sign. Assessment revealed status post fall on 12/10/2011; and back and left buttock pain, rule out disc herniation. The patient was recommended for a trial of TENS unit to help with pain. The patient has been recommended for chiropractic therapy as she it has provided her with 80% relief of her symptoms in the past. Prior utilization review dated 06/20/2014 states the request for chiropractic care for the low back; 12 sessions is denied as there is a lack of documented evidence to support the request.

IMR ISSUES, DECISIONS AND RATIONALES

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

Chiropractic care for the low back; 12 sessions: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines < Manual therapy & manipulation>, page(s) <>> Page(s): 58-59. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) < Chiropractic Therapy for Low Back.

Decision rationale: The ODG treatment guidelines for the Low Back state that "c. Maximum duration: 8 weeks. At week 8, patients should be reevaluated. "Care beyond 8 weeks may be indicated for certain chronic pain patients in whom manipulation is helpful in improving function, decreasing pain and improving quality of life. In these cases, treatment may be continued at 1 treatment every other week until the patient has reached plateau and maintenance treatments have been determined. Extended durations of care beyond what is considered 'maximum' may be necessary in cases of re-injury, interrupted continuity of care, exacerbation of symptoms, and in those patients with comorbidities. Such care should be re-evaluated and documented on a monthly basis. Treatment beyond 4-6 visits should be documented with objective improvement in function."This patient is clearly at a chronic point in her treatment and the requested treatment does not conform to the above accepted treatment guidelines. The review of records showed little documented objective functional improvement and thus the treatment appears palliative. Therefore, the request is not medically necessary. This patient is clearly at a chronic point in her treatment and the requested treatment does not conform to the above accepted treatment guidelines. At this point the patient should be receiving treatment 2 times a month and be moved onto a maintenance schedule. The review of records showed little documented objective functional improvement and thus the treatment appears palliative. Therefore, the request is not medically necessary.