

Case Number:	CM14-0013770		
Date Assigned:	02/26/2014	Date of Injury:	05/16/2009
Decision Date:	07/21/2014	UR Denial Date:	01/09/2014
Priority:	Standard	Application Received:	02/03/2014

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 Chiropractor 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 55-year-old female who has submitted a claim for persistent low back pain with radiculopathy associated with an industrial injury date of 05/16/2009. Medical records from 03/06/2013 to 01/27/2014 were reviewed and showed that patient complained of persistent low back pain graded 8-9/10 radiating to both legs with associated numbness and tingling. Pain is aggravated with physical activities such as prolonged standing and walking and twisting at her torso. Physical examination revealed tenderness of the lumbosacral junction and generalized sacral region. Lateral bending at 0-10 degrees range produced pain. Severe pain was noted with 0-10 degrees back extension. Moderate pain was noted with forward flexion at mid-thigh level. Normal gait and motor strength and reflexes were observed. Negative SLR test was noted in the seated position. EMG-NCV study revealed bilateral S1 chronic subacute radiculopathy. Treatment to date has included transforaminal epidural steroid injection (July 24, 2013), Vicodin 350 mg #15, Oxycodone-Acetaminophen 10/325 mg #50 and Norco 10/325mg #90. Utilization review, dated 01/09/2014, denied the request for twelve visits of chiropractic treatment at two times a week for six weeks for the lumbar spine because there is no documentation describing the number of prior chiropractic visits provided, as well as documentation describing objective improvement from the care provided. There is also no documentation of the patient being actively involved in a home exercise program. With the information provided, there is no support for additional 12 visits of chiropractic care requested 2 times a week for 6 weeks in treatment to the lumbar spine consistent with the CA MTUS Chronic Pain Treatment Guidelines.

IMR ISSUES, DECISIONS AND RATIONALES

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

CHIROPRACTIC TREATMENTS 2X6 FOR THE LUMBAR SPINE: 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 rationale: According to CA MTUS Guidelines, 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. It is not recommended for maintenance care of low back pain. Manipulation, including chiropractic treatment, is a passive treatment. In this case, the patient has received undocumented conservative care visits with unknown outcomes. Furthermore, chiropractic treatment is not recommended for chronic low back pain therapy. It is likewise unclear if patient is actively participating in a home exercise program. The medical necessity was not established due to insufficient information. Therefore, the request for CHIROPRACTIC TREATMENT (PT) TWO (2) TIMES A WEEK FOR SIX (6) WEEKS FOR THE LUMBAR SPINE is not medically necessary.