MAXIMUS Federal Services

Case Number:	CM14-0019163		
Date Assigned:	04/23/2014	Date of Injury:	12/08/2009
Decision Date:	07/03/2014	UR Denial Date:	02/04/2014
Priority:	Standard	Application Received:	02/14/2014

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 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 48-year-old female who was injured on 12/08/2009 while lifting a box that caused back pain. The patient underwent L5-S1 posterior spinal fusion, L5 Gill procedure, L5 bilateral foraminotomy for decompression, L5-S1 intertransverse fusion; L5-S1 posterior instrumentation with US spine pedicle screws, rods and locking caps, use of morselized autograft, use of allograft, iliac crest bone marrow aspiration, and use of PRP application for wound healing on 02/14/2002. Diagnostic studies reviewed include x-ray of the lumbar spine revealed L5 spondylosis. MRI of the lumbar spine with contrast dated 05/21/2013 demonstrates a status post fusion OP L5-S1 with discoplasty. There is no evidence of spondylolisthesis seen. There is suggestion of facet arthropathy at this level. According to physical therapy notes dated 01/21/2014, the patient responded well to physical therapy intervention. The patient demonstrated improved range of motion and pain levels, decreased pain with resistance testing and relief of radicular symptoms in the lower extremity. PR2 dated 12/23/2013 states the patient is recommended an independent home exercise program as she responds well to mechanical traction. A home unit would greatly help her at home. PR2 dated 11/11/2013 indicates the patient has continued pain in the low back. The treatment and plan notes an authorization is requested for ESI injection. PR2 dated 10/14/2013 notes authorizations were requested for chiropractic treatment with [redacted] for the lumbar twice a week for 6 weeks; ESI injections and physical therapy with [redacted] for the lumbar twice a week for 6 weeks.

IMR ISSUES, DECISIONS AND RATIONALES

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

CHIROPRACTIC 2 TIMES A WEEK FOR 6 WEEKS FOR THE LUMBAR SPINE: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines MANUAL THERAPY & MANIPULATION Page(s): 58-59.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines MANUAL THERAPY & MANIPULATION Page(s): 58-59.

Decision rationale: As per CA MTUS, Manual therapy is recommended for chronic pain if caused by musculoskeletal conditions. 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 the 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. Low back: Recommended as an option Therapeutic care- Trial of 6 visits over 2 weeks with evidence of objective functional improvement, total of up to 18 visits over a 6-8 week. Elective/maintenance care: Not medically necessary. Recurrence/flare-ups: Need to re-evaluate treatment success, if RTW achieved then 1-2 visits every 4-6 months. The patient has already received 18 Chiropractic sessions as well as 22 Physical Therapy sessions. There was no documentation in the records as to what functional improvement was achieved with the prior treatment nor there is documentation of future goal as to what increase in functional capacity will occur with additional future care. The requested chiropractic treatment 2x week for 6 weeks is not supported by the CA MTUS guidelines and therefore is not certified.