

Case Number:	CM14-0137117		
Date Assigned:	09/05/2014	Date of Injury:	06/28/2000
Decision Date:	10/09/2014	UR Denial Date:	08/12/2014
Priority:	Standard	Application Received:	08/25/2014

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 Physical Medicine & Rehabilitation and is licensed to practice in Texas and Ohio. 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 injured worker is a 49 year old female who reported an injury on 06/28/2000. The mechanism of injury was not specified. Her diagnoses included cervical spine strain/sprain with radicular complaints, bilateral shoulder rotator cuff tear, and left wrist tenosynovitis. Her diagnostics and past treatments were not provided. It was reported she had 4 lumbar spine surgeries (L4-S1 fusion). On 07/23/2014, the injured worker reported continuous intermittent moderate neck and low back pain. The pain radiated to the bilateral upper extremities with numbness and tingling in the hands bilaterally, and constant numbness throughout the right leg. The physical examination included increased tone and tenderness at the paralumbar musculature and decreased sensation to the right lower extremity. Examination of the cervical spine revealed restricted range of motion due to pain and decreased sensation in the C5, C6, C8 dermatomes on the right. Her medications were not provided. The treatment plan was for chiropractic treatment 1 time per week for 6 weeks and for a lumbar brace. The rationale for the request for the chiropractic treatment was not given and the rationale for the lumbar brace was so that it could assist her with activities of daily living. The request for authorization form was submitted on 07/31/2014.

IMR ISSUES, DECISIONS AND RATIONALES

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

Chiropractic treatment, 1 time a week for 6 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 rationale: Based on the clinical information submitted for review, the request for chiropractic treatment 1 time per week for 6 weeks is not medically necessary. As stated in the California MTUS Guidelines, manual therapy is recommended for chronic pain if caused by musculoskeletal conditions. Several studies of manipulation have looked at duration of treatment, which generally showed measured improvement within the first few weeks or 3-6 visits of chiropractic treatment, although improvement tapered off after the initial sessions. If chiropractic treatment is going to be effective, there should be some outward sign of subjective or objective improvement within the first 6 visits. The injured worker reported intermittent moderate neck and low back pain. She was status post 4 lumbar spine surgeries (L4-S1 fusion). Although it was noted that the injured worker had decreased sensation throughout the right lower extremity and decreased sensation in the C5, C6, and C8 dermatomes with restricted range of motion, there is no indication of any significant functional deficits to include decreased motor strength and quantified range of motion values. Furthermore, the request failed to provide what location of the body would be treated. As such, the request for chiropractic treatment 1 time per week for 6 weeks is not medically necessary.

Lumbar Brace: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back Chapter, Back Brace

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 300. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back, Lumbar Supports.

Decision rationale: Based on the clinical information submitted for review, the request for lumbar brace is not medically necessary. The CA MTUS/ACOEM Guidelines state lumbar supports have not been shown to have any lasting benefit beyond the acute phase of symptom relief. As stated in the Official Disability Guidelines, lumbar supports are not recommended for prevention, but are suggested as an option for treatment. There is strong and consistent evidence that lumbar supports were not effective in preventing neck and back pain. They are recommended as an option for compression fractures and specific treatment of spondylolisthesis, documented instability, and treatment of nonspecific low back pain. The injured worker reported intermittent moderate neck and low back pain. She was status post 4 lumbar spine surgeries (L4-S1 fusion). The guidelines support the use of lumbar supports in the acute phase of treatment. The injured worker's injury is beyond the acute phase; therefore, use of a lumbar brace is not supported. As such, the request for lumbar brace is not medically necessary.

