

Case Number:	CM14-0150161		
Date Assigned:	09/18/2014	Date of Injury:	08/21/2013
Decision Date:	10/17/2014	UR Denial Date:	09/09/2014
Priority:	Standard	Application Received:	09/15/2014

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, has a subspecialty in Acupuncture 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 injured worker is a 42 year old male who reported upper back and low back pain from injury sustained on 08/21/13 while he was unloading boxes weighing 50 pounds each from truck when he developed pain. There were no diagnostic imaging reports. Patient is diagnosed with cervical spine sprain/strain, lumbar spine sprain/strain, myospasm, cervical disc protrusion, lumbar disc protrusion, tension headaches and insomnia. Per medical notes dated 08/15/14, patient complains of upper back pain rated at 6/10; pain radiates to bilateral shoulders. There is no numbness or tingling sensation. Pain is increased at night and decreases with ibuprofen. Patient complains of constant low back pain rated at 6/10, he states that the pain radiates to his hip and legs with numbness and tingling sensation. Pain increased with a lot of movement and lifting; it decreased with pain medication. Patient also complains of bilateral ankle pain rated at 5/10 that radiates to his feet and calves with numbness, tingling and burning sensation. Examination revealed tenderness to palpation with spasms of suboccipitals and upper trapezius muscles. Range of motion of the cervical spine is limited. There is tenderness to palpation with spasm of thoracic and lumbar spine paraspinal muscles with decreased range of motion. Provider is requesting 2x6 acupuncture sessions for the lumbar and thoracic spine.

IMR ISSUES, DECISIONS AND RATIONALES

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

Chiropractic 2 times per week for 6 weeks for the lumbar and thoracic region: 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 and Manipulation Page(s): 58-59.

Decision rationale: Per MTUS- Chronic Pain medical treatment guideline - Manual therapy and manipulation Page 58-59. "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 objectively measureable gain in functional improvement that facilitate progression in the patient's therapeutic exercise program and return to productive activities". 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 6-8 weeks. Elective/ maintenance care- not medically necessary. Reoccurrences/ flare-ups- need to re-evaluate treatment success, if RTW achieved then 1-2 visits every 4-6 months. Treatment parameters from state guidelines. A) Time of procedure effect: 4-6 treatments. B) Frequency 1-2 times per week the first 2 weeks as indicated by the severity of the condition. Treatment may continue at 1 treatment per week for the next 6 weeks. C) Maximum duration: 8 weeks. At 8 weeks patient should be re-evaluated. Care beyond 8 weeks may be indicated for certain chronic pain patients in whom manipulation has been helpful in improving function, decreasing pain and improving quality of life. Treatment beyond 4-6 visits should be documented with objective improvement in function". It is unclear if the patient has had prior Chiropractic treatment or if the request is for initial trial of care. Guidelines recommend trial of 6 visits over 2 weeks, with evidence of objective functional improvement. The requested visits exceed the quantity supported by cited guidelines. Medical reports reveal little evidence of significant changes or improvement in findings, revealing a patient who has not achieved significant objective functional improvement to warrant additional treatment (if any previously administered). Per review of evidence and guidelines, 2X6 Chiropractic visits are not medically necessary.