

Case Number:	CM14-0158951		
Date Assigned:	10/13/2014	Date of Injury:	09/28/2006
Decision Date:	11/12/2014	UR Denial Date:	09/17/2014
Priority:	Standard	Application Received:	09/29/2014

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 Preventive Medicine, has a subspecialty in Occupational Medicine and is licensed to practice in Iowa. 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:

This patient is a 53 year old employee with date of injury of 9/28/2006. The medical records were reviewed. Medical records indicate the patient is undergoing treatment for intervertebral disc degeneration, chronic cervical strain, right great toe MP strain and lumbosacral radiculitis. Subjective complaints include lower back pain radiating into both leg with numbness and tingling. Pain is aggravated by sitting, bending, walking, lifting and pushing or pulling. The pain prevents her from sleeping at night. Her pain has extended to her buttocks causing it to be difficult to sit and rise up from a seated position. Objective findings include straight leg raise on the right and left at 45 degrees causes lower back pain; swelling and tenderness upon palpation at L3-L5, right sacroiliac joint. At T5-T7, C4 to C6 short right leg. She has pain upon lumbar spine extension and flexion. She walks with an antalgic gait. She has weakness of her bilateral quadriceps and hamstring muscles. She has pain upon cervical spine extension and left lateral flexion. Treatment has consisted of physical therapy, acupuncture, chiropractic care, interferential unit, medications (not known) and a back support. The utilization review determination was rendered on 9/17/2014 recommending non-certification of chiropractic manipulation three times a week for four weeks.

IMR ISSUES, DECISIONS AND RATIONALES

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

Chiropractic manipulation three times a week for four weeks: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 10 Elbow Disorders (Revised 2007), Acupuncture Treatment Guidelines, Chronic Pain Treatment Guidelines Manual therapy & manipulation Page(s): 58, Postsurgical Treatment Guidelines.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Manual therapy & manipulation Page(s): 58-60. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back - Lumbar & Thoracic (Acute & Chronic), Chiropractic, Manipulation

Decision rationale: Official Disability Guidelines recommends chiropractic treatment as an option for acute low back pain, but additionally clarifies that "medical evidence shows good outcomes from the use of manipulation in acute low back pain without radiculopathy (but also not necessarily any better than outcomes from other recommended treatments). If manipulation has not resulted in functional improvement in the first one or two weeks, it should be stopped and the patient reevaluated." Additionally, MTUS states "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. Recurrences/flare-ups - Need to reevaluate treatment success, if RTW achieved then 1-2 visits every 4-6 months." The request is in excess of the recommended trial of 6 visits over 2 weeks. As such, the request for chiropractic manipulation three times a week for four weeks is not medically necessary.

Re-evaluation, starting from DOS 8/25/14: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 289, 296. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back, Office Visits

Decision rationale: ACOEM states concerning low back complaints: "Assessing Red Flags and Indications for Immediate Referral Physical-examination evidence of severe neurologic compromise that correlates with the medical history and test results may indicate a need for immediate consultation. The examination may further reinforce or reduce suspicions of tumor, infection, fracture, or dislocation. A history of tumor, infection, abdominal aneurysm, or other related serious conditions, together with positive findings on examination, warrants further investigation or referral. A medical history that suggests pathology originating somewhere other than in the lumbosacral area may warrant examination of the knee, hip, abdomen, pelvis or other areas." The treating physician has not provided the specific goal of the reevaluation and has not provided documentation to meet the above ACOEM guidelines for reevaluation low back complaints. As such the request for Re-evaluation, starting from DOS 8/25/14 is not medically necessary at this time.

