

Case Number:	CM14-0174487		
Date Assigned:	10/27/2014	Date of Injury:	05/14/2014
Decision Date:	12/03/2014	UR Denial Date:	10/07/2014
Priority:	Standard	Application Received:	10/21/2014

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, 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 52 year old male who reported right shoulder and low back pain from injury sustained on 05/14/14 after he fell off a stepladder. X-rays of lumbar spine revealed degenerative disc disease at multiple levels. MRI of the lumbar spine revealed severe spinal stenosis at L3-4 and L4-5 with extruded disc herniation at L3-4. Patient is diagnosed with lumbar disc herniation with spinal stenosis. Patient has been treated with medication, physical therapy, chiropractic and epidural injection. Per medical notes dated 09/22/14, patient complains of knee, shoulder and low back pain. He complains of constant moderate to severe pain in the lower back with frequent radiation of the pain into the right leg and pain is associated with a cramping sensation and numbness. Patient complains of intermittent shoulder pain and constant right knee pain. Per medical notes dated 10/02/14, patient reports ongoing symptoms in his back into his right greater than left leg. Patient had an epidural injection with no relief. Examination revealed decreased range of motion and tenderness to palpation of the paraspinal muscles. Per medical notes dated 10/02/14, patient is considered a candidate for operative lumbar decompression as he has failed conservative care. Provider requested additional chiropractic sessions for lumbar spine. 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.

IMR ISSUES, DECISIONS AND RATIONALES

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

Chiropractic Care: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Chiropractic Treatment

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, pages 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 facilitates 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 is 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". Patient has had prior chiropractic treatments; however, clinical notes fail to document any functional improvement with prior care. Per medical notes dated 10/02/14, patient is considered a candidate for operative lumbar decompression as he has failed conservative care. Provider requested additional chiropractic sessions for lumbar spine. 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. Per guidelines, functional improvement means either a clinically significant improvement in activities of daily living or a reduction in work restrictions as measured during the history and physical exam. Per review of evidence and guidelines, additional Chiropractic visits are not medically necessary.