

Case Number:	CM14-0178392		
Date Assigned:	10/31/2014	Date of Injury:	09/09/1999
Decision Date:	12/08/2014	UR Denial Date:	10/09/2014
Priority:	Standard	Application Received:	10/27/2014

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 Illinois. 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 46-year-old female who reported an injury on 09/09/1999 due to an unknown mechanism. Diagnoses were lumbago, lumbar spasm, and knee pain/leg. Past treatments were TENS unit, chiropractic, medications, walking, swimming, and acupuncture. Physical examination dated 09/23/2014 revealed that the injured worker was noted that she could walk 4 blocks with 50% less pain. The injured worker was able to sleep better at night. Examination revealed limited painful dorsolumbar range of motion with pain on end range. Range of motion was flexion was to 50 degrees, extension was to 15 degrees, bilateral flexion was to 10 degrees, left lateral rotation was to 10 degrees, and right rotation was to 15 degrees. There was palpable tenderness of the dorsolumbar paraspinals, a positive straight leg at 40 degrees with pain to the right lower extremity. Medications were not reported. Treatment plan was for 6 chiropractic and 6 acupuncture sessions. The Request for Authorization was not submitted.

IMR ISSUES, DECISIONS AND RATIONALES

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

Six (6) Chiropractic visits to include CMT, EMS Manual Therapy, Therapeutic Exercises, and Ultrasound: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 299-300, Chronic Pain Treatment Guidelines Manual Therapy &

Manipulation. Decision based on Non-MTUS Citation Non-MTUS Official Disability Guidelines (ODG), Low Back - Lumbar & Thoracic (Acute & Chronic).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Manual Therapy Page(s): 58-59.

Decision rationale: The California Medical Treatment Utilization Schedule states that manual therapy and manipulation is recommended for chronic pain if caused by musculoskeletal conditions. For the low back, therapy is recommended initially in a therapeutic trial of 6 sessions and with objective functional improvement, a total of up to 18 visits over 6 to 8 weeks may be appropriate. Treatment for flare ups requires a need for re-evaluation of prior treatment success. Treatment is not recommended for the ankle and foot, carpal tunnel syndrome, the forearm, wrist, and hand, or the knee. If chiropractic treatment is going to be effective, there should be some outward sign of subjective or objective improvement within the first 6 visits. Treatment beyond 4 to 6 visits should be documented with objective improvement in function. The maximum duration is 8 weeks, and at 8 weeks patients should be re-evaluated. Care beyond 8 weeks may be indicated for certain chronic pain patients in whom manipulation is helpful in improving function, decreasing pain, and improving quality of life. The physical examination did not indicate that this was a flare up or an ongoing problem for the injured worker. There was no documentation that the injured worker had returned to work. There was no documentation of objective functional improvement from previous chiropractic sessions. The clinical information submitted for review does not provide evidence to justify 6 chiropractic visits. Therefore, the request for Six (6) chiropractic visits to include CMT, EMS manual therapy, therapeutic exercises, and ultrasound is not medically necessary.

One (1) exam: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain (Chronic).

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain, Office Visit.

Decision rationale: The Official Disability Guidelines recommend office visits for proper diagnosis and return to function of an injured worker. The need for clinical office visit with a healthcare provider is individualized based upon a review of the patient's concerns, signs and symptoms, clinical stability, and reasonable physician judgment. As patient's conditions are extremely varied, a set number of office visits per condition cannot be reasonably established. The determination of necessity for an office visit requires individualized case review and assessment, being ever mindful that the best patient outcomes are achieved with the eventual patient independence from the healthcare system through self care as soon as clinically feasible. The request does not indicate what type of examination is being requested. There was no rationale submitted with documentation of a patient's concerns, signs or symptoms, medications. The clinical information submitted for review does not provide evidence to justify the decision for 1 exam. Therefore, the request for one (1) exam is not medically necessary.

