

Case Number:	CM14-0182433		
Date Assigned:	11/07/2014	Date of Injury:	01/27/1999
Decision Date:	12/16/2014	UR Denial Date:	10/21/2014
Priority:	Standard	Application Received:	11/03/2014

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 and 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 patient is a 73 year old male with a date of injury of 11/02/2000. He had a spine surgery in 2000 and in 2001. On 06/27/2006 he had a spinal cord stimulator. On 07/13/2013 he had a urine drug test that was positive for prescribed hydrocodone. On 10/17/2013 another urine test was positive appropriately. On 12/05/2013 Norco was discontinued and he was started on Percocet. On 01/09/2014 and on 04/10/2014 he had low back pain, lower extremity pain and difficulty walking. Lumbar range of motion was decreased. Posture was mildly kyphotic. Straight leg raising was positive bilaterally. He continues to walk but also uses an electric scooter. Pain was 4-9/10. On 01/09/2014 and on 04/10/2014 his urine drug screen was appropriate fro the prescribed medications.

IMR ISSUES, DECISIONS AND RATIONALES

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

Chiropractic therapy 2-4 visits/month: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Manual therapy & 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 gains 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". The patient has had prior chiropractic treatments; however, clinical notes fail to document any functional improvement with prior care. Provider requested additional 2-4 visits/month of chiropractic sessions. Per chiropractic progress notes dated 10/14/14, patient complains of low back pain, sacroiliac pain on the right, low back and neck pain and stiffness remains unchanged. 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. Requested visits exceed the quantity supported by cited guidelines. Per review of evidence and guidelines, additional 2-4visits/month of Chiropractic visits is not medically necessary.