

Case Number:	CM14-0030156		
Date Assigned:	06/20/2014	Date of Injury:	02/01/2011
Decision Date:	07/23/2014	UR Denial Date:	02/14/2014
Priority:	Standard	Application Received:	03/10/2014

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 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:

Progress report dated 01/30/2014 indicates the patient complained of pain in the neck, mid/upper back, lower back and bilateral knees which he rated as 7/10. He states his pain has increased from 4/10 to 6-7/10 in the mid/upper back; 6/10 in the lower back from 4/10 on the last visit; and 3/10 on the right knee. Objective findings on exam revealed tenderness to palpation over the paraspinal muscles. Cervical compression and cervical distraction are positive. The thoracic spine revealed 2+ tenderness to palpation over the paraspinal muscles. The lumbar spine revealed tenderness to palpation over the paraspinal muscles. There is restricted range of motion. Straight leg raise test is positive bilaterally. The bilateral knees reveal 2+ tenderness to palpation. Diagnoses are 1) Cervical spine strain/sprain 2) Cervical spine disc protrusion as per MRI dated 11/04/11 3) Thoracic spine strain/sprain disc protrusion as per MRI dated 01/04/13 4) Lumbar spine -strain/sprain with radiculitis 5) Lumbar spine disc disease as per MRI dated 11/04/11 6) Bilateral knee strain/sprain 7) Rule out right knee Internal derangement 8) Rule out right knee meniscal tear 9) Depression,- situational and 10) Sleep disturbance secondary to pain. The treatment and plan included chiropractic therapy to the cervical, thoracic, and lumbar spine as well as to the bilateral knees, two times a week for six weeks. He was prescribed hydrocodone 5/325 mg. Prior utilization review dated 02/14/2014 states the request for chiropractic treatment twice a week for 4 weeks for thoracic spine was not authorized as the patient has had an epidural steroid injection and it did not provide him with any relief and the patient did not attend physical therapy.

IMR ISSUES, DECISIONS AND RATIONALES

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

Chiropractic twice a week for 4weeks for thoracic spine: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Manual therapy & manipulation Page(s): 58-60.

Decision rationale: Patient is a male, age 34 who was injured on 02/01/2011. The mechanism of injury is unspecified/unknown. The decision/request is for Chiropractic visits, 2x week for 4 weeks. Treatment is to be rendered for diagnosis related to the cervical spine, thoracic spine, lumbar spine, knees, bilaterally. MRI examination revealed, possible HNP within the thoracic and lumbar spines. This request is specific to the patient's thoracic spine. Upon reviewing the patient's records, no documentation could be found as to the specific number of Chiropractic visits this patient has had to date nor were there any specific clinically significant signs of objective functional improvement resulting from treatment. Per the Chronic Pain Medical Treatment Guidelines, functional improvement is defined as clinically significant improvement in the patients activities of daily living (ADLs) or as a reduction in work restrictions as would be measured during the history and physical examination performed and documented as part of the evaluation and management procedure with a goal of reducing dependency on medical care and transitioning to an home exercise program (HEP). There is no documentation that the patient is actively or has been involved in an active HEP. Further, the guidelines allow for an initial trial of 6 treatments within the first 2 weeks with up to 18 over a 6-8 week period provided there is continued improvement in functional capacity documented. "Manual therapy & manipulation. 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 objective measurable gains in functional improvement that facilitate the progression in the patient's therapeutic exercise program and return to productive activities. Manipulation is manual therapy that moves a joint beyond the physiologic range-of-motion but not beyond the anatomic range-of-motion. 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 a 6-8 week. Elective/maintenance care - Not medically necessary. Recurrence/flare-ups- Need to re-evaluate treatment success, if RTW achieved then 1-2 visits every 4-6 months. Per The guidelines captioned above, decision for Chiropractic visits 2 x weeks for 4 weeks, and is not medically necessary.