

Case Number:	CM15-0005285		
Date Assigned:	01/16/2015	Date of Injury:	03/11/1998
Decision Date:	03/10/2015	UR Denial Date:	12/19/2014
Priority:	Standard	Application Received:	01/09/2015

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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:

State(s) of Licensure: California

Certification(s)/Specialty: Chiropractic

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 54 year old female, who sustained an industrial injury on 3/11/1998. The diagnoses have included degeneration of lumbar or lumbosacral intervertebral disc and myalgia and myositis, unspecified. Treatment to date has included conservative measures. Currently, the injured worker complains of moderate to severe low back pain with radiation to the left lower extremity. The injured worker was noted to try physical therapy and medications, without significant relief for the last six months. Similar symptoms were reported two years prior, with improvement after chiropractor and decompression therapy, noting symptoms subsided over a year. No specific results or specific dates of service from the referenced prior chiropractic were noted. Ability to perform activities of daily living was limited due to pain and anxiety. Moderately severe tenderness and spasm was present on the bilateral facets and bilateral paraspinal muscles at C4-C7 and upper trapezius. Tenderness and spasm was noted on the bilateral facets and bilateral paraspinal muscles at L1-L5, gluteus maximus, and leg. Magnetic resonance imaging of the lumbar spine from 7/06/2012 was referenced as showing facet hypertrophy at L1-S1 and disc herniation with moderate foraminal stenosis at L4-S1. Plan included refer to chiropractor for decompression and treatment. Number of sessions have not been specified. On 12/19/2014, Utilization Review non-certified a request for chiropractic manipulation and spinal decompression therapy for the lumbar spine (number of sessions unspecified, as an outpatient), citing MTUS Chronic Pain Medical Guidelines.

IMR ISSUES, DECISIONS AND RATIONALES

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

Chiropractic manipulation and spinal decompression therapy for the lumbar spine, number of sessions not specified, as an outpatient: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Manual Therapy & Manipulation Section.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Low Back Chapter, Manipulation Section Page(s): 58. Decision based on Non-MTUS Citation Low back Chapter MTUS Definitions

Decision rationale: This patient has received prior chiropractic care. The ODG Low Back Chapter and The MTUS Chronic Medical Treatment Guidelines for Recurrences/flare-ups states : "Need to re-evaluate treatment success, if RTW achieved then 1-2 visits every 4-6 months when there is evidence of significant functional limitations on exam that are likely to respond to repeat chiropractic care." The MTUS-Definitions page 1 defines functional improvement as a "clinically significant improvement in activities of daily living or a reduction in work restrictions as measured during the history and physical exam, performed and documented as part of the evaluation and management visit billed under the Official Medical Fee Schedule (OMFS) pursuant to Sections 9789.10-9789.11; and a reduction in the dependency on continued medical treatment." The PTP describes some Improvements with treatment but no objective measurements are listed. Stating that the pain has decreased and range of motion increase does not provide objective functional improvement data as defined in The MTUS. The records provided by the primary treating chiropractor do not show objective functional improvements with ongoing chiropractic treatments rendered. The chiropractic care records are not present in the records provided. Furthermore, The MTUS does not recommend decompression therapy. I find that the unspecified number of chiropractic sessions to include decompression therapy, requested to the lumbar spine, to not be medically necessary and appropriate.