

Case Number:	CM14-0122713		
Date Assigned:	08/08/2014	Date of Injury:	09/19/2012
Decision Date:	10/16/2014	UR Denial Date:	07/14/2014
Priority:	Standard	Application Received:	08/04/2014

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 a licensed Doctor of 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 42 year old male who reported low back pain from injury sustained on 09/19/12. He was turning to the left while carrying a part and had placed his foot on the platform; patient slipped on fiberglass which was on the floor and fell. MRI of the lumbar spine dated 02/26/13 revealed displacement of intervertebral disc without myelopathy. EMG/NCS studies dated 03/14/13 revealed acute bilateral L5-S1 radiculopathies; mild bilateral lateral plantar sensory demyelinating neuropathies. Patient is diagnosed with lumbar disc displacement without myelopathy; lumbar radiculitis; lumbar sprain/strain; loss of sleep and anxiety. Patient has been treated with medication, therapy, acupuncture and Chiropractic. Per medical notes dated 04/02/14, patient complains of stiffness to the lumbar spine. Patient has constant moderate to severe pain in the low back region. Patient complains of loss of sleep due to pain. Patient also suffers from anxiety and depression. Per medical notes dated 05/02/14, patient complains of stiffness of the lumbar spine. Patient has constant, moderate pain in the low back region that increases with prolonged sitting activities. Range of motion of the lumbar spine is limited. There is tenderness to palpation of the bilateral SI joints and lumbar paravertebral muscles. Provider is requesting additional 6X3 chiropractic treatments. 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 3 x wk x 6 wks lumbar spine: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Manual therapy and manipulation Page(s): 58-59.

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". Patient has had prior chiropractic treatments with symptomatic relief; however, clinical notes fail to document any functional improvement with prior care. . 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. Furthermore, requested visits exceed the quantity supported by cited guidelines. Per review of evidence and guidelines, 6 X 3 Chiropractic visits are not medically necessary.