

Case Number:	CM14-0143363		
Date Assigned:	09/10/2014	Date of Injury:	09/02/2008
Decision Date:	10/10/2014	UR Denial Date:	08/27/2014
Priority:	Standard	Application Received:	09/04/2014

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 Chiropractor, has a subspecialty in Acupuncture and is licensed to practice in New York. 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:

Upon review of the medical records provided the applicant was a 68 year old male who sustained a work related injury that occurred on September 2, 2008 while employed by [REDACTED]. Thus far treatment has consisted of physical therapy, chiropractic and medications. The applicant was diagnosed with chronic back pain, peripheral neuropathy versus plantar fasciitis and lumbar radiculopathy. MRI of the lumbar spine dated 10/14/08 demonstrated mild degenerative changes L5/S1 with 2 mm disc bulge creating slight flattening of the anterior spinal canal and slight narrowing of the left neural foramen L5/S1. There is a past medical history significant for insulin dependent diabetes mellitus, diabetic neuropathy, hypertension, right great toe cellulitis and obesity. Upon review of PR2 report dated 8/1/14 the applicant presented with complaints of intermittent lower back pain that is rated a 5-6/10 with radiation into the right buttock to the knee. His gait was indicated as being markedly antalgic with a boot cast on the left foot. He is walking the aide of a cane. He has numbness and tingling right foot to toes which is secondary to his diabetes. Lumbar spinal examination revealed spasms, lumbar ranges of motion were indicated as being restricted in all planes of motion, sensation was diminished at the bilateral L3-S1 dermatomes. The bilateral tibialis anterior and EHL are 4/5, bilateral straight leg raise was with numbness of the bilateral toes at 45 degrees. A diagnosis was given as: chronic back pain, peripheral neuropathy versus plantar fasciitis and lumbar radiculopathy. He was advised to continue on medications Flexeril and Tramadol daily and Capsaicin cream for pain as well as chiropractic treatment with therapeutic modalities two times per week for three weeks. His disability status was permanent and stationary per AME. In a utilization review report dated 8/27/14 the reviewer determined the proposed chiropractic treatment two times per week for three weeks was not-certified. The reviewer indicated the records did not establish how many prior chiropractic treatment sessions were received as well as the objective functional

improvement achieved from prior chiropractic treatment, therefore additional treatment was not recommended. There was no indication of a home back exercise program; there was no flare up of the condition which would necessitate further treatment. This determination was based upon the CA MTUS Chronic Pain Medical Treatment Guidelines Manual Therapy and Manipulation.

IMR ISSUES, DECISIONS AND RATIONALES

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

Chiropractic Care 2x Week for 3 Weeks: 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 8.V.V.T. 9792.20-9792.26 Manual Therapy & Manipulation Chapter Page(s): 58-59.

Decision rationale: Upon review of a medical note dated 5/1/13 provided by [REDACTED] there was an indication that prior 8 session's chiropractic treatment was received with decreased pain and increased function. The follow-up examinations do not demonstrate this. The proposed chiropractic treatment two times per week for three weeks was not medically necessary or appropriate in this particular case as well as it is not sanctioned under the CA MTUS Chronic Pain Medical Treatment Guidelines Manual Therapy and Manipulation Guidelines. The MTUS guidelines recommend continued treatment only with evidence of functional improvement. The records show the applicant continues to be symptomatic as well as there was no indication of a reduction in objective clinical findings. Medications were continued for pain. The medical records reviewed do not indicate any specific documented functional improvement from chiropractic manipulation. Chiropractic treatment two times per week for three weeks is not medically necessary or appropriate.