

Case Number:	CM14-0147629		
Date Assigned:	09/15/2014	Date of Injury:	09/06/2013
Decision Date:	10/17/2014	UR Denial Date:	09/09/2014
Priority:	Standard	Application Received:	09/11/2014

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 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 41 year old female who reported neck, upper back and low back pain from injury sustained on 09/16/13 due to a slip and fall. MRI of the lumbar spine revealed spondylitic changes and multilevel disc bulges. MRI of the brain was unremarkable. Patient is diagnosed with lumbago; swelling in head/neck; lumbosacral neuritis; lumbar disc displacement; lumbar root injury and cervicgia. Patient has been treated with medication, physical therapy and chiropractic. Per medical notes dated 06/26/14, patient complains of neck, left shoulder and head pain rated at 9/10. Pain is associated with tingling and weakness in the left shoulder. Medications help relieve the pain. Patient complains of stabbing pain in the low back which radiates to the left lower extremity. Pain is rated at 8/10. Pain is associated with tingling and weakness in the lumbar spine and left leg. Examination revealed decreased range of motion of the cervical spine and lumbar spine. Per medical notes dated 08/07/14, patient complains of sharp neck pain rated at 6/10, radiating to the left elbow. She also complains of severe low back pain which is constant with chronic headaches. Provider requested additional 2 times 6 Chiropractic treatments. There is no assessment in the provided medical records of functional efficacy with prior Chiropractic visits. 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:

Outpatient chiropractic treatment to the cervical spine and lumbar spine, two (2) times a week for six (6) weeks: Upheld

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

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 gain sin 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 guidelines. Per review of evidence and guidelines, 12 Chiropractic visits are not medically necessary.