

Case Number:	CM14-0161315		
Date Assigned:	10/06/2014	Date of Injury:	01/17/2013
Decision Date:	10/31/2014	UR Denial Date:	09/29/2014
Priority:	Standard	Application Received:	10/01/2014

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 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 44 year old female whom sustained an industrial injury that occurred on January 17, 2013 while employed by [REDACTED] as a health aide paraprofessional. The applicant fell landing with her feet up in the air and she hit her head on the ground. Thus far, treatment has consisted of 6 chiropractic treatments with temporary relief, TENS and medication. The applicant also utilized Tramadol and Lidoderm Patches. The applicant was diagnosed with L5/S1 disc displacement or degeneration, left leg radiculopathy, right leg radiculopathy, cervical strain with degeneration, C5/6 spondylosis, C4-C6 degenerative disc disease and acute onset of headaches. X-ray of the lumbar spine revealed mild disc space narrowing L5/S1 indicating slight disk degeneration, mild spondylotic degenerative change at L4/5 and mild S shaped scoliosis. As per review of primary treating physician's orthopedic spine surgery narrative report dated 9/17/14 the applicant at that time had completed six sessions of chiropractic care with temporary relief of her symptoms. The applicant continued to subjectively complain of lower back pain which radiates into right lower extremity to the heel in the S1 dermatome, rated a 9 without medications and 7 with medications on VAS (visual analog scale). The pertinent examination findings revealed the following: There was no evidence of weakness walking on the toes and heels, tenderness over the lumbosacral junction and across upper buttocks bilaterally, sensation was intact in the bilateral lower extremities, there were no restrictions of lumbar ranges of motion, there was no muscle weakness of the lower extremities. In a utilization review report dated 9/29/14 the reviewer determined that the proposed additional chiropractic therapy 2 times per week for three weeks to the lumbar spine was not medically necessary and therefore non-certified as per the CA MTUS Chronic Pain Medical Treatment Guidelines. The applicant at that time underwent 6 sessions with pain relief; however no objective updates from prior intervention were indicated.

IMR ISSUES, DECISIONS AND RATIONALES

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

Additional chiropractic therapy 2 times a week for 3 weeks for the lumbar spine: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ACOEM Guidelines, 2nd Edition, 2004, page 127, the Official Disability Guidelines (ODG), Office Visits

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

Decision rationale: The applicant was a 44 year old female whom sustained an industrial injury that occurred on January 17, 2013. An injury was sustained to the neck and lower back region. The records indicated the applicant has received 6 chiropractic treatments that provided only temporary relief. The applicant continues to take medication. Despite the noted course of treatment the applicant has remained symptomatic with examination findings minimal. There were no lumbar range of motion deficits; there was no muscle spasm of the lumbar spine noted, there was no lower extremity weakness or sensory deficits noted. The straight leg raise was notated as being positive on the right. There is no significance to this. There was no indication what this was positive for or what the specific response by the applicant to the testing performed. The proposed chiropractic treatment two times a week for 3 weeks is 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. Although there were subjective complaints of palpable tenderness to the lumbar spine there were no objective clinical findings to substantiate the need for any further chiropractic treatment in this point in time. Additional chiropractic treatment at this point in time has been utilized to their maximum for the expected results and to continue their implementation on a supportive basis is not sanctioned under the guidelines.