

Case Number:	CM14-0089189		
Date Assigned:	07/23/2014	Date of Injury:	04/15/2008
Decision Date:	10/10/2014	UR Denial Date:	06/10/2014
Priority:	Standard	Application Received:	06/13/2014

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 & 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 55 year old male who reported neck and low back pain from injury sustained on 04/15/08. Mechanism of injury was not documented in the provided medical records. MRI of the lumbar spine revealed 3.4mm disc protrusion at L5-S1 that abuts the thecal sac with a posterior annular tear/fissure and pseudo retrolisthesis of L5 on S1. Electrodiagnostic studies of the lower extremity revealed bilateral L4, L5, S1 radiculopathy, lumbosacral plexopathy and right tarsal tunnel syndrome. Patient is diagnosed with status post cervical spine discectomy and fusion, status post revision anterior to posterior cervical spine surgery, cervical radiculopathy, disc herniation L5-S1 and bilateral L4, L5 and S1 radiculopathy. Patient has been treated with 2 cervical spine surgeries, 1 upper extremity surgery, medication, and physical therapy. Per medical notes dated 05/02/14, patient complains of ongoing pain to his cervical spine radiating down bilateral upper extremities with numbness, tingling and weakness to the arms and hands. Patient also complains of continues pain and stiffness to his lumbar spine radiating down bilateral legs with numbness and tingling to bilateral lower extremity. Examination revealed tenderness over the paraspinous musculature with spasms. Per medical notes dated 05/28/14, patient complains of neck and low back pain. Primary treating physician is requesting Chiropractic 2X6 for the lumbar spine.

IMR ISSUES, DECISIONS AND RATIONALES

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

Chiropractic Therapy two times per week for six weeks for the lumbar spine: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines/Integrated Treatment Guidelines (ODG - Treatment in Workers' Compensation 2nd edition)- Disability Duration guidelines(Official Disability Guidelines 9th edition)/Work Loss Data Institute

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, pages 58-59 indicates, 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 measurable gain in functional improvement that facilitates 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 and 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 indicate, 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". It is unclear if the patient has had prior chiropractic care or if the request is for initial trial of care. Per MTUS guidelines, time to produce effect is between 4-6 treatments and treatment beyond that should be documented with objective functional improvement. Provider is requesting 2X6 chiropractic visit which exceeds the quantity supported by cited guidelines. Medical records fail to document any functional deficits or functional goals which the provider hopes to accomplish with the requested care. Per review of evidence and guidelines, 2X6 Chiropractic visits are not medically necessary.