

Case Number:	CM14-0168121		
Date Assigned:	10/16/2014	Date of Injury:	10/15/2008
Decision Date:	02/06/2015	UR Denial Date:	09/11/2014
Priority:	Standard	Application Received:	10/13/2014

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 Internal Medicine 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 (IW) is a 63-year-old man with a date of injury of October 15, 2008. The mechanism of injury occurred as a result of a single lifting event. The injured worker's working diagnoses are cervical spine herniated nucleus pulposus; lumbar spine sprain and strain; left knee sprain and strain; sleep deprivation; stress anxiety and depression; and gastritis. Prior treatment has included physical therapy, chiropractic treatment, and medications. There is a clinical not in the medical record dated October 2008, and the most recent not dated August 27, 2014. There was no documentation or clinical notations between 2008 and 2014. The documentation consists of a single Qualified Medical Examination (QME) dated August 27, 2014. All other documentation consists of progress notes in 2008. Pursuant to the QME from August 27, 2014, the IW complains of lumbar spine pain described as constant sharp, shooting pain that goes into his extremities. There were additional complains associated with his neck, bilateral shoulders, left knee, and sleep deprivation. Examination of the lumbar spine reveals paraspinal spasms. Kemp's test was positive bilaterally. Under the history of injury on page 2 of the August 27, 2014 qualified medical evaluator's note, the physician documented the IW was treated with the chiropractor and treatment was procured. He underwent MRIs and was seen for medical treatment including injections. The chiropractor "advised the IW he could no longer treat as his therapy was no longer beneficial". There is no documentation in the medical record consisting of physical therapy or chiropractic notes. There is no clinical evidence of objective functional improvement in the record. Additionally, there was no frequency or specific number of chiropractic visits requested. The current request is for chiropractic treatment 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 treatment for the lumbar spine: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Chiropractic treatment Page(s): 58-60. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG); Low Back Section, Manipulation.

Decision rationale: Pursuant to the Chronic Pain Medical Treatment Guidelines and the Official Disability Guidelines, chiropractic treatment for the lumbar spine is not medically necessary. The Official Disability Guidelines enumerated the frequency and duration for chiropractic treatment. Under therapeutic care, mild, up to 6 visits over two weeks. For severe, trial of six visits over two weeks and with evidence of objective functional improvement, a total of up to 18 visits over 6 to 8 weeks may be required. Avoid chronic care; elective/maintenance care is not medically necessary. Recurrences and flare-ups reevaluate treatment success; if returned to work then once two visits every 4 to 6 months when there is evidence of significant functional limitation on exam likely to respond to chiropractic care. In this case, the injured worker's working diagnoses are cervical spine herniated nucleus pulposus; lumbar spine sprain and strain; left knee sprain and strain; sleep deprivation; stress anxiety and depression; and gastritis. The documentation consists of a single Qualified Medical Examination dated August 27, 2014. All other documentation consists of progress notes in 2008. Under the History of Injury on page 2 of the August 27, 2014 qualified medical evaluator's note, the physician documented the injured worker was treated with the chiropractor and treatment was procured. He underwent MRIs and was sent from medical treatment including injections. The chiropractor "advised the injured worker he could no longer treat as his therapy was no longer beneficial". There is no documentation in the medical record consisting of physical therapy or chiropractic notes. There is no clinical evidence of objective functional improvement in the record. Additionally, there was no frequency or specific number of chiropractic visits requested. Consequently, based on the chiropractic admission that his therapy was no longer beneficial and no chiropractic documentation indicating objective functional improvement, chiropractic treatment for the lumbar spine is not medically necessary.