

Case Number:	CM15-0006997		
Date Assigned:	01/29/2015	Date of Injury:	08/01/2006
Decision Date:	03/19/2015	UR Denial Date:	12/31/2014
Priority:	Standard	Application Received:	01/13/2015

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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:
 State(s) of Licensure: California
 Certification(s)/Specialty: Chiropractic

CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

This male was injured 8/1/06 in an industrial accident. He complains of low back pain radiating to bilateral lower extremities with numbness and tingling and sleep disturbance due to pain. Pain intensity is 7/10. He currently takes Arthrotec, Ramipril, Vytarin and Prevacid. Diagnoses are osteoarthritis and pain in joint of lower leg. Treatments include chiropractic visits, home exercise program and gym exercises. There were no diagnostic noted. The treating physician requested chiropractic visits as they helped the injured worker manage pain flare-ups, decrease medication and stay functional. On 12/31/14 Utilization Review non-certified the request for chiropractic twice a week for four weeks for the lumbar spine citing MTUS: Chronic Pain Medical Treatment Guidelines: Manual Therapy & Manipulation.

IMR ISSUES, DECISIONS AND RATIONALES

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

Chiropractic care for the lumbar spine, twice weekly for four weeks: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Manual Therapy and Manipulation Section Page(s): 58 - 59.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Manual Therapy & Manipulation Section Page(s): 58. Decision based on Non-MTUS Citation Low Back Chapter

Decision rationale: The patient has sustained work related injuries to his knee and lower back. The patient has received prior chiropractic care to his low back per the records provided. The MTUS Chronic Pain Medical Treatment Guidelines recommends additional care with evidence of objective functional improvement. The ODG Low Back Chapter for Recurrences/flare-ups states : "Need to re-evaluate treatment success, if RTW achieved then 1-2 visits every 4-6 months when there is evidence of significant functional limitations on exam that are likely to respond to repeat chiropractic care." The MTUS-Definitions page 1 defines functional improvement as a "clinically significant improvement in activities of daily living or a reduction in work restrictions as measured during the history and physical exam, performed and documented as part of the evaluation and management visit billed under the Official Medical Fee Schedule (OMFS) pursuant to Sections 9789.10-9789.11; and a reduction in the dependency on continued medical treatment." The PTP describes some Improvements with treatment but no objective measurements are listed. Stating that the pain has decreased and range of motion increase does not provide objective functional improvement data as defined in The MTUS. The records provided by the primary treating physician do not show objective functional improvements with ongoing chiropractic treatments rendered. The chiropractic care records are not present in the records provided. I find that the 8 chiropractic sessions requested to the lumbar spine to not be medically necessary and appropriate.