

Case Number:	CM14-0188077		
Date Assigned:	11/18/2014	Date of Injury:	07/02/2014
Decision Date:	10/27/2015	UR Denial Date:	10/16/2014
Priority:	Standard	Application Received:	11/12/2014

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. 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, Minnesota

Certification(s)/Specialty: Chiropractor

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 is a 43-year-old male worker with a date of injury 7-2-2014. The medical records indicated the injured worker (IW) was treated for thoracic sprain and strain; spasm of muscle; and thoracic or lumbosacral neuritis or radiculitis, unspecified. In the 9-9-14 progress notes, the IW reported right-sided low back pain, rated 6 out of 10, with some extension to the right lower extremity, rated 4 out of 10, with some weakness. Objective findings on 9-9-14 included tightness of the quadratus lumborum and right low back extensors. Ranges of motion were measured (in degrees) at 55 forward flexion, 28 extension, 70 right rotation, 80 left rotation, 28 right lateral bending and 32 left lateral bending. Diminished pinwheel sensation was noted over the right S1 dermatome and less so over the L5 dermatome. Ankle jerks were 2+ on the left and 1+ on the right. Patellar reflexes were +2 bilaterally. Seated straight leg raise was to 80 degrees on the right and 85 degrees on the left. He complained of pain in the right lower back pain radiating down the right lower extremity. Gaenslen's test was positive on the right for right-sided sacral ala pain. Milgram's test was positive at 6 seconds for increased low back pain, midline and to the left. Treatments included medications, ice, heat, electrical stimulation unit, home exercises and chiropractic treatments (which improved the mid back pain and right leg symptoms, but was progressing slowly for the right low back pain). The IW was temporarily totally disabled. The treatment plan included continuing chiropractic therapy and home exercises, home electrical muscle stimulation unit and electrodiagnostic testing of the lower extremity. A Request for Authorization was received for eight chiropractic treatments, once a week for eight weeks, for the lumbar spine (outpatient). The Utilization Review on 10-16-14 non-certified the request for eight chiropractic treatments, once a week for eight weeks, for the lumbar spine (outpatient) because the CA MTUS Chronic Pain Medical Treatment Guidelines, ACOEM and Official Disability Guidelines - Treatment in Workers' Comp (ODG-TWC) were not met.

IMR ISSUES, DECISIONS AND RATIONALES

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

Chiropractic treatment, one time a week for eight weeks; 8 sessions 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 Official Disability Guidelines (ODG), www.odg-twc.com; Low Back; ACOEM www.acoempracticeguides.org, Low Back.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Manual therapy & manipulation.

Decision rationale: According to the MTUS Chronic Pain Guidelines above, manipulation of the low back is recommended as an option of 6 trial visits over 2 weeks, with evidence of objective functional improvement, total of up to 18 visits over 6-8 weeks. The doctor has requested chiropractic treatment 1 time per week for 8 weeks or 8 sessions for the lumbar spine. The request for treatment (1x8 visits) is not according to the above guidelines (3x2 or 6 visits) and therefore the treatment is not medically necessary and appropriate.