

Case Number:	CM13-0039048		
Date Assigned:	06/06/2014	Date of Injury:	04/17/2008
Decision Date:	07/14/2014	UR Denial Date:	09/10/2013
Priority:	Standard	Application Received:	10/02/2013

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 and is licensed to practice in Texas. 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 56 year old female who reported an injury on 04/17/2008 due to a fall. On 06/11/2013 she reported neck, shoulder, back, hip, and head pain as well as not being able to bend, lift, climb, and stoop. A physical exam on 04/12/2013 showed that she experienced midline lumbar spine tenderness at lumbosacral junction, Sacroiliac test were positive on the right and negative on the left, and straight leg raise was negative bilaterally. Lumbar spine lateral bend was 20/30 bilaterally, flexion 70/70 and extension 20/30 along with a hip flexion at L2, L3 of 5/5 bilaterally. She had a beck depression inventory of 39, a pain rating of 9/10 frequency and 8/10 with activity. An MRI on 09/10/2013 revealed L2-L3 disc desiccation with endplate degenerative changes and mild facet arthropathy, L1-L2 disc desiccation with endplate degenerative changes as well as a disc protrusion and posterior annular tear, and T1-L1 disc desiccation and a midline disc bulge. Her diagnoses include right sacroiliitis, status post L1-2 micro laminectomy and discectomy, and multilevel lumbar spondylosis and facet joint hypertrophy. Past treatment includes therapy, medications and surgery. Medications included Tizanidine, Tramadol, Hydrochlorothiazide, Losartan, Trazodone, Qvar, and ProAir HFA. The treatment plan is for chiropractic therapy 2 times a week for 3 weeks for the right hip. The request for authorization form and rationale were not provided for review.

IMR ISSUES, DECISIONS AND RATIONALES

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

CHIROPRACTIC 2XWK X 3WKS FOR RIGHT HIP: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Manual therapy & manipulation Page(s): 58-60.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Manual therapy & manipulation Page(s): 58-59.

Decision rationale: The MTUS Chronic Pain Guidelines regarding manual therapy and manipulation, manual therapy is recommended for the use of chronic pain if caused by musculoskeletal conditions to achieve positive symptomatic or objective measureable gains in functional improvement. For the low back, it is recommended as an option with a trial of 6 visits over 2 weeks, with evidence of objective functional improvement a total of up to 18 visits is recommended. However, the injured worker had already had multiple therapy visits dated from 2010-2012 with no evidence documented of improvement in functional status. Given the above, the request is not medically necessary and appropriate.