

Case Number:	CM14-0158575		
Date Assigned:	10/02/2014	Date of Injury:	05/12/2014
Decision Date:	10/29/2014	UR Denial Date:	09/09/2014
Priority:	Standard	Application Received:	09/26/2014

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 Occupational 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 is a 40-year-old female who sustained an injury on May 23, 2014. She is diagnosed with (a) displacement of lumbar intervertebral disc without myelopathy and (b) subluxation/nonalopathic lesion (segmental dysfunction) of the thoracic region. She was seen on August 25, 2014 for an evaluation. She complained of moderate low back pain, mild to moderate left hamstring and calf pain, mild neck pain, and mild left arm pain. Examination of the lumbar spine revealed moderately abnormal range of motion. Moderately hypertonic bilateral paralumbar tissues were noted. There was also moderate tenderness over the area. Examination of the thoracic spine revealed mild to moderate tenderness over the area as well. Examination of the cervical spine revealed mild to moderate tenderness and abnormal range of motion.

IMR ISSUES, DECISIONS AND RATIONALES

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

Chiropractic visits QTY: 8: Upheld

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

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

Decision rationale: The request for chiropractic therapy is not recommended at this time. From the reviewed medical records, it has been determined that the injured worker previously underwent chiropractic therapy. However, no significant objective improvement was noted after four to six treatments. This is necessary to warrant further sessions of chiropractic therapy.

Electro Stim - L spine QTY: 8: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 298-301.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Transcutaneous electrotherapy Page(s): 114-116. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back - Lumbar & Thoracic (Acute & Chronic), Transcutaneous electrical nerve stimulation

Decision rationale: The request for electrostimulation of the lumbar spine is not medically necessary at this time. There was no indication in the reviewed medical records that there was failure of appropriate pain modalities to warrant the need for electrostimulation to the lumbar spine. More so, there was no mention what specific kind of electrostimulation is intended to be used to the lumbar spine.

Electrical stim-thoracic QTY: 8: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 298-301.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Transcutaneous electrotherapy Page(s): 114-116. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back - Lumbar & Thoracic (Acute & Chronic), Transcutaneous electrical nerve stimulation

Decision rationale: The request for electrostimulation of the thoracic spine is not medically necessary at this time. There was no indication in the reviewed medical records that there was failure of appropriate pain modalities to warrant the need for electrostimulation to the thoracic spine. More so, there was no mention what specific kind of electrostimulation is intended to be used to the thoracic spine.