

Case Number:	CM14-0200488		
Date Assigned:	12/10/2014	Date of Injury:	12/30/2005
Decision Date:	02/24/2015	UR Denial Date:	11/17/2014
Priority:	Standard	Application Received:	12/01/2014

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: Ohio

Certification(s)/Specialty: Chiropractor, Oriental Medicine

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 42 year old female who sustained a work related injury December 30, 2005, after a motor vehicle accident with injury to her neck low back. Physician documented MRI results of the lumbar spine, right and left shoulders, and cervical spine dated May 7, 2014(no reports present in case file). According to a pain medicine re-evaluation performed September 15, 2014, the injured worker presents with complaints of neck pain with radiation down the bilateral upper extremities aggravated by activity and walking; low back pain with radiation down the bilateral lower extremities aggravated by activity and walking; upper extremity pain bilaterally in the fingers hands and shoulders; lower extremity pain bilaterally in the hips and ongoing frontal, occipital daily headaches; frequent GERD related medication associated gastrointestinal upset and moderate constipation. According to the physician she has used a TENS unit for the last 5 years, several times a day, home exercise, muscle relaxants and physical therapy with 90% improvement with this regime. Functional improvement is described as ability to care for pet, combing washing hair and bathing, performing laundry, vacuuming, gardening, and hobbies. Cervical examination reveals spinal vertebral tenderness C4-7 with range of motion slightly/moderately limited, and pain was increased with flexion, extension, and rotation. Lumbar examination reveals spasm and tenderness on palpation L4-S1, range of motion was moderately limited secondary to pain which was increased with flexion and extension. Upper extremity examination reveals tenderness on palpation at bilateral anterior shoulders. Diagnoses are documented as; lumbar radiculopathy, headaches, other chronic pain, and s/p post dental trauma, all teeth extracted. Treatment plan included; home exercise program, continued,

smoking cessation program and TENS unit, and continued medication for pain and headaches; Fioricet, Colace, Flexeril, Neurontin, Prilosec, Tramadol, Sumatriptan, and Keflex. Another pain medicine visit dated October 13, 2014, reveals the same documentation as outlined in last visit with no significant changes, exception is cancellation of Keflex. Work status documented as currently not working. According to utilization review performed November 17, 2014, retrospective review, date of service 10/30/2014, for outpatient chiropractic manual therapy 1-2 regions; manual therapy; mechanical traction therapy, and infrared therapy, body part not indicated is non-certified. Citing MTUS Chronic Pain Treatment Guidelines, there was no evidence of functional improvement as a result of the previous course of care therefore; the medical necessity was not established.

IMR ISSUES, DECISIONS AND RATIONALES

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

Retrospective: Chiropractic Manual Therapy 1-2 Regions; Manual Therapy; Mechanical Traction Therapy, and Infrared Therapy (DOS: 10/30/14): Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints, Chapter 8 Neck and Upper Back Complaints Page(s): 181, 300, Chronic Pain Treatment Guidelines Page(s): 55-60.

Decision rationale: MTUS does recommend a trial of 6 visits over 2 weeks with evidence of objective functional improvement. Based on the medical provided, there is no documentation from the treating chiropractor and therefore no objective functional improvement to support the treatment request. The request is not medically necessary based on MTUS guidelines. MTUS states that traction has not been proved effective for lasting relief in treating low back pain. Because evidence is insufficient to support using vertebral axial decompression for treating low back injuries, it is not recommended. Therefore, this request is not medically necessary.