

Case Number:	CM15-0107091		
Date Assigned:	06/11/2015	Date of Injury:	11/18/2013
Decision Date:	07/13/2015	UR Denial Date:	05/12/2015
Priority:	Standard	Application Received:	06/03/2015

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: Arizona, California

Certification(s)/Specialty: Family Practice

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 51 year old female, who sustained an industrial injury on 11/18/2013. Diagnoses include neck pain, thoracic strain, lumbar strain, gastroesophageal reflux disease (GERD), diabetes mellitus, hypertension, hypercholesteremia and obesity. Treatment to date has included medications, injections, modified duty, physical therapy and diagnostics. Per the Medical Legal Evaluation dated 2/06/2015, the injured worker reported pain in the neck and upper and lower back. Physical examination of the cervical spine revealed restricted ranges of motion in all planes. There was excessive tenderness when lightly touching the skin over the spine and paraspinous areas. There was no muscle spasm and trigger points were everywhere. Thoracic and lumbar evaluation revealed excessive pain with light touch to the skin overlying the paraspinous muscles. There was restricted range of motion of the lumbar and thoracic spine. The plan of care included, and authorization was requested for chiropractic therapy (2x3) for the lumbar spine, cervical spine and thoracic spine and an x-ray of the lumbar spine.

IMR ISSUES, DECISIONS AND RATIONALES

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

Chiropractic therapy 2 times a week for 3 weeks for the lumbar spine: Overturned

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 298-299.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Manual Therapy Page(s): 58.

Decision rationale: According to the MTUS guidelines, Chiropractic therapy is considered manual therapy. It is recommended for chronic musculoskeletal pain. For Low back pain, therapeutic care is for 6 visits over 2 weeks with functional improvement up to a maximum of 18 visits over 8 weeks. In this case, the claimant had long-standing low back pain and had undergone therapy and injections. The request for 6 sessions of chiropractor therapy is medically necessary.

X-ray for the lumbar spine: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 309.

Decision rationale: According to the guidelines, x-ray of the lumbar spine is recommended for fracture or red flag findings. It is not recommended for routine use in the 1st month of symptoms. In this case, the claimant had an MRI 1 yr ago showing facet arthropathy. There were no new injury or red flag findings. The x-ray request is not medically necessary.