

Case Number:	CM15-0139105		
Date Assigned:	07/29/2015	Date of Injury:	05/04/2013
Decision Date:	08/26/2015	UR Denial Date:	06/19/2015
Priority:	Standard	Application Received:	07/17/2015

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: California
 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 46 year old female with an industrial injury dated 05/04/2013. Her diagnoses included lumbar disc displacement without myelopathy, lumbar or lumbosacral disc degeneration, lumbago, and chronic pain syndrome and hip and thigh injury not otherwise specified. Prior treatment included ice, heat exercise and medications. She presented on 06/05/2015 radiating to lower back and right leg. The pain is rated as 7/10. She states medications are helping and she tolerates them well. She noted pain level had increased since last visit. Physical examination of lumbar spine revealed tenderness of the paravertebral muscles on the right side. Spinous process was tender at lumbar 3, lumbar 4 and lumbar 5. Straight leg raising test was positive on the right side at 90 degrees in sitting position. Right hip range of motion was limited by pain. There was tenderness over the groin, sacroiliac joint and greater trochanter. Right knee range of motion was restricted by pain. Treatment plan included cognitive behavior therapy; continue with ice, heat, exercise and medications and chiropractic therapy. Work status - modified. The treatment request is for chiropractic therapy for the lumbar spine, eight sessions.

IMR ISSUES, DECISIONS AND RATIONALES

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

Chiropractic therapy for the lumbar spine, eight sessions: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Manual Therapy and Manipulation Page(s): 58-59.

Decision rationale: Patient has not had prior chiropractic treatments. Provider requested initial trial of 8 chiropractic treatment for lumbar spine which were modified to 6 by the utilization review. Per guidelines 4-6 treatments are supported for initial course of Chiropractic with evidence of functional improvement prior to consideration of additional care. Requested visits exceed the quantity of initial Chiropractic visits supported by the cited guidelines. Additional visits may be rendered if the patient has documented objective functional improvement. MTUS-Definition 9792.20 (f) Functional improvement means either a clinically significant improvement in activities of daily living or a reduction in work restrictions as measured during the history and physical exam. Per guidelines and review of evidence, 8 Chiropractic visits are not medically necessary.