

Case Number:	CM15-0030334		
Date Assigned:	02/24/2015	Date of Injury:	12/06/2013
Decision Date:	04/03/2015	UR Denial Date:	01/15/2015
Priority:	Standard	Application Received:	02/18/2015

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 32 year old male, who sustained an industrial injury on 12/6/13. He has reported cervical upper back and low back pain after lifting heavy boxes to load. The diagnoses have included cervical spine strain/sprain with radiculitis, rule out cervical spine discogenic disease, thoracic spine strain/sprain, lumbosacral strain/sprain with radiculitis, and lumbosacral spine disc protrusions. Treatment to date has included medications, diagnostics, physical therapy, Home Exercise Program (HEP), and chiropractic sessions 11 sessions to date. Currently, the injured worker complains of pain in the neck that radiates to upper and lower back. The pain in the neck is rated 8/10 which has increased from 6/10 since last visit. The pain in the upper and lower back is rated 4/10 which has decreased since last visit which was 6/10. The Magnetic Resonance Imaging (MRI) of the lumbar spine dated 8/6/14 revealed disc protrusion, posterior annular tear/fissure, and hemangioma. The physical exam revealed cervical spine has restricted range of motion and compression test was positive. The thoracic spine revealed tenderness to palpation and palpable spasm which was unchanged. The lumbar spine revealed tenderness to palpation, palpable spasm, restricted range of motion and positive straight leg raise bilaterally. The injured worker states that the treatment helps and that the Chiropractic therapy helps decrease the pain and tenderness. He indicated that his function and activities of daily living (ADL's) have improved by 30 percent with the Chiropractic therapy. There is pending authorization for Magnetic Resonance Imaging (MRI) of the cervical spine. Treatment was for additional Chiropractic sessions. Work status was temporary total disability. On 1/15/15 Utilization Review non-certified a request for Chiropractic 2 Times a Week for 6 Weeks for The

Cervical Spine, Thoracic Spine and Lumbar Spine, noting the (MTUS) Medical Treatment Utilization Schedule chronic pain guidelines were cited.

IMR ISSUES, DECISIONS AND RATIONALES

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

Chiropractic 2 Times A Week for 6 Weeks for The Cervical Spine, Thoracic Spine and Lumbar Spine: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines : 2009; 9294.2; manual therapy and manipulation Page(s): 58/59.

Decision rationale: The UR determination of 1/15/15 was an appropriate denial of the requested continuation of Chiropractic care, 12 sessions or 2x6. The reviewed medical records documented completed of 11 dates of service with subjective improvement estimated at 30% with no objective clinical findings by comparative evaluation to support the noted functional gains. The CAMTUS Chronic Treatment Guidelines require evidence of functional improvement prior to consideration of additional care. The UR determination to deny further care is supported by reviewed medical records that do not support the medical necessity for further care based on the absence of residual functional deficits necessitating care and the referenced CAMTUS Chronic Treatment Guidelines that require objective clinical support of functional improvement based on comparative objective clinical deficits.