

Case Number:	CM14-0212319		
Date Assigned:	01/02/2015	Date of Injury:	01/10/2012
Decision Date:	02/28/2015	UR Denial Date:	11/21/2014
Priority:	Standard	Application Received:	12/18/2014

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: 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 63 year old female who reported mid back and low back pain from injury sustained on 01/10/12 due to a fall while carrying an object. Electrodiagnostic studies revealed moderate right L5-S1 radiculopathy and a mild left S1 radiculopathy. Patient is diagnosed with sprain of lumbar region, lumbar disc disease, lumbar radiculopathy, thoracic spine compression fracture. Patient has been treated with medication, physical therapy, epidural injection. Per medication dated 11/11/14, patient reported pain to the upper back and low back. Examination revealed light touch sensation to right mid/anterior thigh, right lateral ankle, and right mid/lateral calf was diminished. Patient has not had prior chiropractic treatments.

IMR ISSUES, DECISIONS AND RATIONALES

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

Chiropractic treatment for the lumbar and thoracic spine; 12 sessions: Upheld

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

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 12 chiropractic treatment for lumbar spine and thoracic spine which were non-certified 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. There is no documentation afforded for review that establishes a clear, updated clinical status of the patient with current objective finding, functional deficits. Per guidelines and review of evidence, 12 Chiropractic visits are not medically necessary.