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| Case Number: | CM15-0102222 | | |
| Date Assigned: | 06/04/2015 | Date of Injury: | 06/25/2014 |
| Decision Date: | 07/09/2015 | UR Denial Date: | 04/27/2015 |
| Priority: | Standard | Application Received: | 05/27/2015 |

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

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 22 year old female who sustained an industrial injury on 6/25/14 while transferring an agitated resident from a shower chair she was twisting while lifting with a co-worker when she felt a sudden sharp shock like sensation from the base of her low back to below her bra line. She currently complains of low back pain with pain level of 5-6/10. Medications are Tramadol, ibuprofen. Diagnoses include myofascial and myoligamentous sprain/ strain of the lumbar spine. Treatments to date include acupuncture, which were extremely beneficial for short time with 50% reduction of pain; physical therapy; medications. Diagnostics include MRI, which was normal. In the progress note dated 4/14/15 the treating provider's plan of care included chiropractic treatments 2X3 for lumbosacral strain/ sprain as she has failed all other conservative treatments.

IMR ISSUES, DECISIONS AND RATIONALES

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

Chiropractic treatments, unspecified frequency and duration: Overturned

Claims Administrator guideline: Decision based on MTUS ACOEM.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Manual Therapy is widely used in the treatment of musculoskeletal pain. The intended goal or effect of Manual Medicine is the achievement of positive symptomatic or objective measurable gains

in functional improvement that facilitate progression in the patient's therapeutic exercise program and return to productive activities. Low back: Recommended as an option. Therapeutic care - Trial of 6 visits over 2 weeks, with evidence of objective functional improvement, total of up to 18 visits over 6-8 weeks. Elective/maintenance care - Not medically necessary. Recurrences/flare-ups - Need to re-evaluate treatment success, if RTW achieved then 1-2 visits every 4-6 months Page(s): 58-59.

Decision rationale: The claimant presented with chronic low back pain despite previous treatments with medications, acupuncture, physical therapy, and home exercises. Reviewed of the available medical records showed no history of prior chiropractic treatments. Current request for 6 chiropractic treatments for the lumbosacral spine is appropriated with evidences based MTUS guidelines recommendation for a trial of 6 visits over 2 weeks. Therefore, the request is medically necessary.