

Case Number:	CM15-0010912		
Date Assigned:	01/30/2015	Date of Injury:	06/08/2012
Decision Date:	03/18/2015	UR Denial Date:	12/24/2014
Priority:	Standard	Application Received:	01/20/2015

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, Minnesota
 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 50 year old female with an industrial injury dated 06/08/2012 which resulted from a slip/fall. Her diagnoses include thoracic disc degeneration, thoracic radiculopathy, lumbar disc degeneration, chronic pain, lumbar radiculopathy, and T12 compression fracture (per MRI 03/05/2013). Recent diagnostic testing (last 6-9 months) was not submitted or discussed. She has been treated with epidural injections (06/27/2014), medications, home exercise program, electrical stimulation, and previous left ankle surgery. In a progress note dated 11/03/2014, the treating physician reports neck pain radiating down the right upper extremity, low back pain radiating into the bilateral lower extremities and accompanied with numbness, tingling and weakness in the right lower extremity, and left lower extremity pain with pain ratings of 6/10 with medications, 8/10 without medications and without changes from previous visit. The objective examination revealed a slow gait with use of a walker, tenderness and spasm in the thoracic paraspinal muscles bilaterally, tenderness to palpation in the bilateral paravertebral area of L5-S1, limited range of motion in the lumbar spine due to pain, decreased sensitivity to touch along the L5-S1 dermatome bilaterally, decreased strength in the bilateral lower extremities, and positive straight leg raises bilaterally. The treating physician is requesting chiropractic therapy which was denied by the utilization review. On 12/24/2014, Utilization Review non-certified a request for chiropractic therapy 2 times per week for 3 weeks for the lumbar spine and right shoulder, noting the absence of subjective and objective findings documented and no mention of whether the injured worker has had prior treatments and whether they provided pain relief or aided in functional improvement. The MTUS Guidelines were

cited. On 01/20/2015, the injured worker submitted an application for IMR for review of chiropractic therapy 2 times per week for 3 weeks for the lumbar spine and right shoulder.

IMR ISSUES, DECISIONS AND RATIONALES

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

Chiropractic 2xwk X 3wks, Lumbar Spine And Right Shoulder 99203 98940 98941, 42 Or 43, Possibly 97110 97140 97026 97750: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Manual Therapy and Manipulation.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines 9792.20-9792.26 Page(s): 58&59.

Decision rationale: The records do not indicate the amount of previous chiropractic care and/or how the patient responded to care using objective measurable gains in functional improvement. According to the MTUS Chronic Pain Guidelines above, manipulation of the low back is recommended as an option of 6 trial visits over 2 weeks, with evidence of objective functional improvement, total of up to 18 visits over 6-8 weeks. The doctor is requesting chiropractic 2x/week for 3 weeks for the lumbar spine and right shoulder. The requested treatment is not according to the above guidelines as well as not revealing how much previous care has been given and documenting objective measurable gains in functional improvement. Therefore the requested care is not medically necessary.