

Case Number:	CM15-0018049		
Date Assigned:	02/05/2015	Date of Injury:	09/16/2014
Decision Date:	03/30/2015	UR Denial Date:	01/13/2015
Priority:	Standard	Application Received:	01/30/2015

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: New Jersey

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 36-year-old male who reported an injury on 09/16/2014. The injured worker was reportedly attacked by a client. The injured worker presented with complaints of low back pain, right shoulder pain, and right forearm pain. Additionally, the injured worker reported activity limitation. The current diagnoses include lumbar spine strain, right shoulder strain, and right forearm strain. Upon examination, there was mild, diffuse tenderness to palpation along the AC joint and biceps tendon, rotator cuff tenderness, negative instability test, positive impingement test, negative drop arm test, diminished range of motion, diffuse tenderness of the right forearm, tenderness to palpation in the lumbar paravertebral muscles at L4 and S1, and diminished lumbar range of motion and 2+ deep tendon reflexes, intact sensation and negative straight leg raise. Recommendations at that time included chiropractic, 3 times per week for 4 weeks, a urine drug test, and prescriptions for Naprosyn 550 mg and Ultracet. A Request for Authorization form was then submitted on 01/06/2015.

IMR ISSUES, DECISIONS AND RATIONALES

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

Chiropractic 3x4 Weeks for Lumbar consisting of Manual Therapy, Therapeutic Exercise, Infrared, Physical Test/Measurement with Report: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 48 and 58.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 58.

Decision rationale: The California MTUS Guidelines state manual therapy is recommended for chronic pain if caused by a musculoskeletal condition. Treatment is recommended as a therapeutic trial of 6 visits over 2 weeks. The current request for 12 sessions of manual therapy exceeds guideline recommendations. Therefore, the request is not medically appropriate at this time.