

Case Number:	CM15-0128481		
Date Assigned:	07/14/2015	Date of Injury:	05/20/2011
Decision Date:	08/12/2015	UR Denial Date:	06/16/2015
Priority:	Standard	Application Received:	07/02/2015

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 51 year old female, who sustained an industrial injury on 5/20/11. The initial complaints were low back pain with injury at work. The diagnoses have included low back pain, degenerative disc disease (DDD), lumbar sprain, sleep disturbance and painful spasms of the back. Treatment to date has included medications, activity modifications, pain management, acupuncture and physical therapy. The diagnostic testing that was performed included x-rays and Magnetic Resonance Imaging (MRI) of the lumbar spine. The diagnostic reports were not noted in the records. Currently, as per the physician progress note dated 5/28/15, the injured worker complains of interscapular pain rated 10/10 on pain scale with radiation to the left upper extremity. The objective findings reveal s decreased range of motion of the lumbosacral spine and tenderness to palpation of the thoracic lumbar spine. The previous therapy sessions were not noted. The work status is modified with restrictions. The physician requested treatment included Chiropractic Manipulations to the Lumbar area Two (2) times a week for four (4) weeks.

IMR ISSUES, DECISIONS AND RATIONALES

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

Chiropractic Manipulations to Lumbar, Two (2) times a week for four (4) weeks: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines 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 2X4 chiropractic treatment for lumbar spine which was 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. Per guidelines and review of evidence, 2X4 Chiropractic visits are not medically necessary.