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| Case Number: | CM15-0063567 | | |
| Date Assigned: | 04/10/2015 | Date of Injury: | 09/22/2006 |
| Decision Date: | 05/08/2015 | UR Denial Date: | 03/31/2015 |
| Priority: | Standard | Application Received: | 04/03/2015 |

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: Emergency 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 was a 65 year old female, who sustained an industrial injury, September 22, 2006. The injured worker received the following treatments in the past Percocet, Zantac, Aspirin, 6 chiropractic treatments, physical therapy, ice, anti-inflammatories and home exercise program. The injured worker was diagnosed with axial low back pain secondary to degenerative disc disease/degenerative joint disease, left gluteus medius strain chronic, lumbar paraspinal strain chronic and rule out left S1 joint dysfunction. According to progress note of February 23, 2015, the injured workers chief complaint was worsening back, hip and leg pain. The injured worker was having trouble moving some days. The injured worker was having concerns with falling due to weakness secondary to pain. The physical exam noted the injured worker walked with a single point cane. The injured worker had a slow and guarded gait. The injured worker had to stop and rest while walking down the hallway, which was approximately 60 feet. The injured worker was exquisitely tender over the bilateral greater trochanter, greater on the right. There was tenderness along the lumbar paraspinals and gluteus muscles. The treatment plan included bilateral ultrasound guided injections for the trochanteric bursitis and 6 sessions of chiropractic treatments.

IMR ISSUES, DECISIONS AND RATIONALES

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

Bilateral ultrasound guidance: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints, Chronic Pain Treatment Guidelines.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Hip & Pelvis (Acute & Chronic), Injections.

Decision rationale: The requested Bilateral trochanteric injections with ultrasound guidance, is not medically necessary. CA MTUS is silent. Official Disability Guidelines, Hip & Pelvis (Acute & Chronic), Injections, are only recommended with severe hip osteoarthritis. The injured worker has worsening back, hip and leg pain. The treating physician has documented tenderness over the bilateral greater trochanter, greater on the right. There was tenderness along the lumbar paraspinals and gluteus muscles. The treating physician has not documented diagnostic evidence of severe hip osteoarthritis. The criteria noted above not having been met, Bilateral trochanteric injections with ultrasound guidance is not medically necessary.

Chiropractic Treatment x 6 additional sessions: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Manual Therapy and Manipulation, Pages 58-59.

Decision rationale: The requested Chiropractic Treatment x 6 additional sessions, is not medically necessary. CA MTUS Chronic Pain Treatment Guidelines, Manual Therapy and Manipulation, Pages 58-59, recommend continued chiropractic therapy with documented objective evidence of derived functional benefit. The injured worker has worsening back, hip and leg pain. The treating physician has documented tenderness over the bilateral greater trochanter, greater on the right. There was tenderness along the lumbar paraspinals and gluteus muscles. The treating physician has not documented objective evidence of derived functional benefit from completed chiropractic sessions, such as improvements in activities of daily living, reduced work restrictions or reduced medical treatment dependence. The criteria noted above not having been met, Chiropractic Treatment x 6 additional sessions is not medically necessary.