

Case Number:	CM15-0066406		
Date Assigned:	04/14/2015	Date of Injury:	08/18/2010
Decision Date:	05/13/2015	UR Denial Date:	03/13/2015
Priority:	Standard	Application Received:	04/07/2015

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 35-year-old male, who sustained an industrial injury on 8/18/2010. He reported low back pain. The injured worker was diagnosed as having bilateral sacroiliac joint dysfunction. Treatment to date has included medications, and sacroiliac joint injection. The request is for Chiropractic treatment for the lumbar spine. On 3/5/2015, he is seen for flare of low back pain with radiation into the buttock area. He rated his pain as 8/10 on visual analog scale. He is status post a bilateral sacroiliac joint injection completed 10/2014, which gave him 60-80% pain relief for 6-8 weeks. The treatment plan included: Naprosyn, Robaxin, Voltaren gel, Chiropractic therapy and bilateral sacroiliac joint injection. He is to continue working without restrictions.

IMR ISSUES, DECISIONS AND RATIONALES

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

Chiropractic 2 times a week for 3 weeks (6 sessions) lumbar spine: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines manual therapy & manipulation Page(s): 58-60.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines : 2009; 9294.2; pages 58/59: manual therapy and manipulation.

Decision rationale: The UR determination of 3/12/15 denied the request for additional Chiropractic care, 2x3 of 6 visits citing CA MTUS Chronic Treatment Guidelines. The determination was based on the reviewed Chiropractic records that reflected prior Chiropractic care of 12 sessions that did not result in any documented clinical evidence of functional improvement as required by the CA MTUS Chronic Treatment Guidelines for consideration of additional care. Although the 3/5/15 report from the requesting provider did outline reexamination findings, evidence of functional improvement was not provided supporting the request for additional care. The reviewed records do not reflect the medical necessity for additional Chiropractic care, 6 sessions or comply with CA MTUS Chronic Treatment Guidelines that require objective clinical evidence of functional improvement as the criteria for additional care.