

Case Number:	CM15-0075900		
Date Assigned:	04/27/2015	Date of Injury:	03/18/2013
Decision Date:	05/26/2015	UR Denial Date:	04/09/2015
Priority:	Standard	Application Received:	04/21/2015

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 29 year old female, who sustained an industrial injury on March 18, 2013. She has reported back pain, leg pain, and wrist pain. Diagnoses have included lumbar spine intervertebral disc disorder, left knee tendonitis, thoracic spine pain, bilateral wrist tenosynovitis, lumbar spine myofascitis/myositis, thoracic spine myalgia/myofascitis, thoracic spine muscle spasm, and bilateral buttock muscle spasm. Treatment to date has included medications and diagnostic testing. A progress note dated March 2, 2015 indicates a chief complaint of left knee pain, lower back pain radiating to the legs, hips and buttocks, mid back pain, and bilateral wrist pain. The treating physician documented a plan of care that included medications and spinal manipulation.

IMR ISSUES, DECISIONS AND RATIONALES

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

4 spinal manipulation 1 times a week for 4 weeks throacic spine unspecified if inpatient or outpatient: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines manual therapy and manipulation Page(s): 58-59.

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

Decision rationale: The UR determination of 4/9/15 denied the request for Chiropractic care, 4 visits citing CAMTUS Chronic Treatment Guidelines. The treatment request for 4 Chiropractic visits was not accompanied by the patient past medical history of care or reported evidence of a recent flare or exacerbation where initiation of Chiropractic care would be reasonable or necessary. The reviewed medical records fail to establish the medical necessity for Chiropractic care, 4 sessions or comply with the criteria for care per CAMTUS Chronic Treatment Guidelines. Therefore, the requested treatment is not medically necessary.