

Case Number:	CM15-0076396		
Date Assigned:	04/28/2015	Date of Injury:	07/30/2013
Decision Date:	05/28/2015	UR Denial Date:	04/08/2015
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

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 40 year old female, who sustained an industrial/work injury on 7/30/13. She reported initial complaints of upper back, lower back, left shoulder/arm, left forearm, left hip, right knee, left knee and right ankle/foot pain. The injured worker was diagnosed as having subscapularis bursitis, left shoulder strain, left hip strain. Treatment to date has included medication, physical therapy, chiropractic care, epidural steroid injection, and acupuncture. MRI results were reported on 10/16/13, 10/18/13, and 12/21/13. Currently, the injured worker complains of low back pain radiating to the left hip and left shoulder pain rated 5/10. Per the secondary physician's progress report (PR-2) on 1/30/15, the injured worker feels weak all over body, nauseated, headaches. Shoulder and back pain persists. Diagnosis is lumbar facet arthropathy and lumbar myofascial pain. The requested treatments include chiropractic therapy for the lumbar spine.

IMR ISSUES, DECISIONS AND RATIONALES

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

Chiropractic therapy 2 times a week for 6 weeks for the lumbar spine: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Manual therapy & manipulation.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Manual Therapy is widely used in the treatment of musculoskeletal pain. The intended goal or effect of Manual Medicine is the achievement of positive symptomatic or objective measurable gains in functional improvement that facilitate progression in the patient's therapeutic exercise program and return to productive activities. Low back: Recommended as an option. Therapeutic care Trial of 6 visits over 2 weeks, with evidence of objective functional improvement, total of up to 18 visits over 6-8 weeks. Elective/maintenance care Not medically necessary. Recurrences/flare-ups Need to re-evaluate treatment success, if RTW achieved then 1-2 visits every 4-6 months
Page(s): 58-59.

Decision rationale: The claimant presented with chronic low back pain. Reviewed of the available medical records showed she has had chiropractic treatment previously, however, there is no evidences of objective functional improvement. The claimant continued to have pain that required trigger point injections and epidural injections and more medications. The request for 12 chiropractic therapy visits also exceeded the guidelines recommendation for flare-up. Therefore, it is not medically necessary.