

Case Number:	CM15-0090008		
Date Assigned:	05/14/2015	Date of Injury:	10/30/2010
Decision Date:	08/11/2015	UR Denial Date:	05/05/2015
Priority:	Standard	Application Received:	05/11/2015

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: Chiropractic

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 (IW) is a 65 year old female who sustained an industrial injury on 10/30/2010. The mechanism of injury and initial report of injury are not found in the records reviewed. The injured worker was diagnosed as having neural encroachment L4-5 and L5-S1 with radiculopathy, facet osteoarthropathy L4-5 and L5-S1, right hip osteoarthropathy and tensor fascia tendinitis, and left shoulder pain. Treatment to date has included chiropractic care and medications with diagnostic radiology. Currently, the injured worker complains of pain in the low back with right greater than left lower extremity symptoms. The low back pain is rated as a 7 on a scale of 1-10. She has right hip pain she rates as a 5 on a scale of 1-10, and she has right shoulder pain also rated a 5 on a scale of 1-10. Objectively, she has tenderness of the lumbar spine and range of motion that is diminished in all planes. Her lumbo paraspinal muscle spasms have decreased. Her right hip and right shoulder exam are unchanged. She has limited motion with pain. Chiropractic treatment of the lumbar spine is requested at 2 times per week for 4 weeks with emphasis on active therapy including strengthening and work hardening. The notation states she "remains relatively deconditioned as a result of disuse". Treatment plans are inclusive of medications for pain including Tramadol ER, cyclobenzaprine, gabapentin, and hydrocodone. Chiropractic care is part of the treatment plan. A request for authorization is made for the following: Outpatient additional chiropractic treatment to lumbar spine 2 times a week for 4 weeks.

IMR ISSUES, DECISIONS AND RATIONALES

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

Outpatient chiropractic treatment to lumbar 2 times a week for 4 weeks: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines chiropractic treatment, manual therapy and manipulation.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Manual Therapy & Manipulation MTUS Definitions Page(s): 58/1. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back/Manipulation.

Decision rationale: The patient has received chiropractic care for her lumbar spine injury in the past. One past chiropractic treatment note is present in the materials provided and was reviewed. Additional chiropractic progress reports are not available in the records for review. The total number of chiropractic sessions provided to date are unknown and not specified in the records provided for review. Regardless, the treatment records submitted for review do not show objective functional improvement with past chiropractic care rendered, per MTUS definitions. The MTUS Chronic Pain Medical Treatment Guidelines recommends additional care with evidence of objective functional improvement. The ODG Low Back Chapter also recommends 1-2 additional chiropractic care sessions over 4-6 months with evidence of objective functional improvement. The MTUS-Definitions page 1 defines functional improvement as a "clinically significant improvement in activities of daily living or a reduction in work restrictions as measured during the history and physical exam, performed and documented as part of the evaluation and management visit billed under the Official Medical Fee Schedule (OMFS) pursuant to Sections 9789.10-9789.11; and a reduction in the dependency on continued medical treatment." There has been no objective functional improvements with the care in the past per the treating chiropractor's progress note reviewed. The requested number of additional sessions far exceeds The MTUS recommended number. I find that the 8 additional chiropractic sessions requested to the lumbar spine to not be medically necessary and appropriate.