

<b>Case Number:</b>	CM13-0055217		
<b>Date Assigned:</b>	04/25/2014	<b>Date of Injury:</b>	04/22/2013
<b>Decision Date:</b>	06/11/2014	<b>UR Denial Date:</b>	10/17/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	11/20/2013

### 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. The expert reviewer is Board Certified in Occupational Medicine and is licensed to practice in California. 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

### 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 patient is a 62 year-old female with date of injury of 04/22/2013. The medical record associated with the request for authorization, included the primary treating physician's progress report, dated 10/10/2013, which lists the subjective complaints as right low back pain that is aching and sharp. She describes it as constant pain, with intermittent sharp pain radiating down the right buttock. The patient underwent an MRI of the lumbar spine on 06/27/2013, which diagnosed her with mild to moderate degenerative disc disease and mild lower degenerative facet disease. The findings were most notable for moderate left neuroforaminal stenosis at L5-S1. The objective findings included: an examination of the lumbar spine, which revealed tenderness of the right lumbar paraspinals, right iliac crest and right sacroiliac joint. The patient had upper thoracic scoliosis with compensatory lumbar curvature. The right hip rides higher than the left. There was decreased range of motion. The diagnoses include: 1. Strain of lumbar region; 2. Back pain; 3. Lumbar radiculopathy; and 4. Scoliosis. The medical records provided for review show no evidence that the patient has completed any physical therapy to date, although she has been approved for six (6) sessions. She has undergone twelve (12) visits of chiropractic care.

### 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 TIMES 3 WEEKS FOR THE LOW BACK:** 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 & MANIPULATION Page(s): 58-60.

**Decision rationale:** The Chronic Pain Guidelines indicate that chiropractic treatment should be authorized for four to six (4-6) visits. The patient should be reevaluated at that time for evidence of functional improvement. This patient has had twelve (12) chiropractic treatments and her physical exam is relatively unchanged since prior to starting chiropractic care. The medical records do not document any functional improvement as a result of her chiropractic treatment. The request for chiropractic care two (2) times a week for three (3) weeks for the low back is not medically necessary.