

<b>Case Number:</b>	CM14-0163958		
<b>Date Assigned:</b>	10/08/2014	<b>Date of Injury:</b>	10/19/2013
<b>Decision Date:</b>	11/24/2014	<b>UR Denial Date:</b>	09/11/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/06/2014

### 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 Chiropractor and is licensed to practice in Virginia. 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 injured worker is a 59-year-old female with a reported injury on 10/19/2013. The mechanism of injury was not provided. The injured worker's diagnoses included status post Lumbar Laminectomy, lumbar intervertebral disc disorder, right piriformis syndrome and stress related cephalgia. The injured worker's past treatments included chiropractic care and surgery. On the clinical note dated 07/30/2014, the injured worker rated her pain 3/10 to 4/10 in the cervical, thoracic, lumbar spine. The injured worker had tenderness over the interspinous spaces with articular fixations noted at L3-4, L4-5, and L5-S1. The injured worker had restricted flexion of the sacroiliac joint with positive Yeoman's test with Faber producing right sacroiliac joint pain. The injured worker's medications were not provided. The request was for chiropractic x1 weekly x6 weeks for lumbar spine. The rationale for the request was due to previous chiropractic treatments helping. The Request for Authorization Form was not submitted for review.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Chiropractic 1xwk x 6wks Lumbar Spine:** 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 Chiropractic Page(s): 58-60.

**Decision rationale:** The request for Chiropractic x1 weekly x6 Weeks for lumbar spine is not medically necessary. The injured worker was diagnosed with status Post Lumbar Laminectomy, lumbar intervertebral disc disorder, right piriformis syndrome, and stress related cephalgia. The California MTUS Guidelines recommend chiropractic therapy for chronic pain if caused by musculoskeletal conditions. 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 and functional improvement that facilitate progression in the patient's therapeutic exercise program and return to productive activities. Low back is recommended as an option for therapeutic care. A trial of 6 visits over 2 weeks, with evidence of objective functional improvement, up to 18 visits over 6 to 8 weeks. The lack of documentation indicating the number of visits that the injured worker has previously completed, as well as the efficacy of the previous therapy. The requesting physician did not provide a recent clinical note with an assessment of the injured worker's condition. As such, the request for Chiropractic x1 weekly x6 week's Lumbar Spine is not medically necessary.