

<b>Case Number:</b>	CM14-0025821		
<b>Date Assigned:</b>	06/13/2014	<b>Date of Injury:</b>	08/27/2013
<b>Decision Date:</b>	07/29/2014	<b>UR Denial Date:</b>	02/13/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	02/28/2014

### 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 Licensed in Chiropractor, has a subspecialty in Acupuncture and is licensed to practice in Texas. 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 54-year-old male who reported an injury on 08/27/2013 due to an unknown mechanism of injury. On 01/31/2014, he reported pain in the mid back rated at a 6/10 and pain in the low back rated at a 6-6.5/10. He was experiencing radicular symptoms in the right lower extremity. The physical examination revealed tenderness to palpation along the mid thoracic and lumbosacral spine, there was also tenderness to palpation along the thoracolumbar paraspinal muscles, more so on the left than the right. Also, straight leg raise test was positive on the right and negative on the left. There were no signs of motor weakness or sensory deficit. His diagnoses included a lumbar sprain and thoracic back strain. His medications included Excedrin on an as needed basis. Previous therapies included medications and chiropractic therapy. The treatment plan was for chiropractor 8 visits. The request for authorization form was signed on 02/04/2014. The rationale for treatment was not provided.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**CHIROPRACTOR 8 VISITS:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Manual therapy & manipulation Page(s): 58-59.

**Decision rationale:** The injured worker reported a 6/10 pain in the mid back and a 6-6.5/10 pain in the low back. It appears that he has had prior chiropractic treatment but the number of attended sessions was not specified. The California MTUS Guidelines state that manual therapy and manipulation is recommended for chronic pain if caused by a musculoskeletal condition. For the low back it is recommended as an option with therapeutic care trial of 6 visits and up to 18 visits with evidence of functional improvement. There is no evidence documented of functional improvement with the prior sessions to determine efficacy of treatment. In addition, the number of sessions attended was not stated. The guideline recommendations do not support the request. Given the above, the request is not medically necessary.