

<b>Case Number:</b>	CM14-0076849		
<b>Date Assigned:</b>	07/18/2014	<b>Date of Injury:</b>	10/27/2013
<b>Decision Date:</b>	08/25/2014	<b>UR Denial Date:</b>	04/25/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	05/27/2014

### 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 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 33-year-old male who reported an injury on 10/27/2013. The mechanism of injury was not provided. On 04/02/2014, the injured worker presented with low back pain. Upon examination of the lumbar spine, there was tenderness to palpation in the upper column and mid and lower paravertebral muscles. The range of motion values were 20 degrees of flexion, 15 degrees of right lateral bending, 20 degrees of left lateral bending, 20 degrees of right lateral rotation, 25 degrees of left lateral rotation and 15 degrees of extension. There was increased pain with lumbar motion. Diagnoses were cervical radicular syndrome, contusion and straining injury of the thoracic spine, contusion and straining injury of the lumbar spine, thoracic disc protrusion, T6-11 and cervical disc protrusion C3-7. Prior therapy included chiropractic care and medication. The provider recommended outpatient chiropractic sessions. The provider's rationale was not provided. The request for authorization form was not included in the medical documents for review.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Outpatient Chiropractic Sessions two (2) times a week for six (6) weeks for a total of twelve (12) sessions:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303, Chronic Pain Treatment Guidelines Manual therapy and manipulation Page(s): 58-59, 100.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Page(s): 58.

**Decision rationale:** The request for outpatient chiropractic sessions, 2 times a week for 6 weeks for a total of 12 sessions is not medically necessary. The California MTUS Guidelines state that chiropractic care for chronic pain caused by musculoskeletal conditions is recommended. The goal is the achievement of positive symptomatic or objective measurable gains in functional improvement, and to facilitate progression in the injured worker's therapeutic exercise program and return to productive activities. The guidelines recommend a trial of 6 visits over 2 weeks, and with evidence of objective functional improvement. A total of up to 18 visits over 6 to 8 weeks. There was lack of documentation indicating the injured worker had significant objective functional improvement with the prior therapy. Additionally, the amount of chiropractic sessions that the injured worker has already completed was not provided. The provider's request does not indicate the site in which the chiropractic session was intended for. As such, the request is not medically necessary.