

<b>Case Number:</b>	CM14-0003166		
<b>Date Assigned:</b>	01/31/2014	<b>Date of Injury:</b>	10/14/2013
<b>Decision Date:</b>	05/01/2015	<b>UR Denial Date:</b>	12/12/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	01/09/2014

### 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. 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: Chiropractor, Oriental Medicine

### 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 50 year old male, who sustained an industrial injury on 10/14/2013. He has reported subsequent back and left hip pain and was diagnosed with contusion of the lower back, thoracic sprain/strain, contusion of the left hip and lumbosacral sprain. Treatment to date has included oral pain medication, physical therapy, electrical stimulation, infrared heat, myofascial release, therapeutic exercises, application of heat and ice and bracing. In a progress note dated 11/15/2013, the injured worker complained of continued intermittent low back pain. Objective findings were notable for tenderness of the paravertebral musculature with restricted range of motion of the back. The physician noted that the injured worker would complete physical therapy and that if symptoms continued, chiropractic therapy would be attempted for better effect. A request for authorization of Chiropractic therapy was submitted.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**CHIRO 6 VISITS:** Overturned

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines MANUAL THERAPY AND MANIPULATION Page(s): 58-59.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines: 2009; 9294.2; manual therapy and manipulation Page(s): 58/59.

**Decision rationale:** The UR determination to deny requested Chiropractic care, 6 sessions cited CAMTUS Chronic Treatment Guidelines. The patient was reported s/p 6 PT sessions with medication management and topical anti-inflammatory cream. There was no reported history of an manual therapy prior to this request. THE reviewed medical records of medical management did not reflect any prior Chiropractic care management leaving this request an initial trial of care that per CAMTUS Chronic Treatment Guidelines would be 6 sessions. The reviewed medical records support the medical necessity for initiation of Chiropractic care for a trial of 6 sessions following the 11/20/13 evaluation by the patients primary physician. Care as requested is supported by referenced CAMTUS Chronic Treatment Guidelines. Therefore, the request is medically necessary.