

<b>Case Number:</b>	CM14-0031905		
<b>Date Assigned:</b>	06/20/2014	<b>Date of Injury:</b>	07/02/2012
<b>Decision Date:</b>	04/08/2015	<b>UR Denial Date:</b>	02/24/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	03/13/2014

### 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

### 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 male who sustained an industrial injury on 07/02/12. He reports lumbar spine pain with radicular symptoms. Diagnoses include lumbar strain, lumbar radicular syndrome, and lumbar disc extruded herniation L5-S1 with protrusion and annular tear at the L4-5 level. Treatments to date include chiropractic treatments, physical therapy, and an ESI, per the Utilization Review. In a progress note on 01/21/14, the treating provider recommended additional chiropractic treatment. On 02/24/14, Utilization Review non-certified the chiropractic treatments, citing MTUS guidelines.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Chiropractic Treatment for the Lumbar Spine 2 times per week for 6 weeks:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines Chiropractic Guidelines.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines The Expert Reviewer based his/her decision on the MTUS 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 in functional improvement that facilitate progression in the patient's therapeutic exercise program and return to productive activities. Low back: Recommended as an option. Therapeutic care - Trial of 6 visits over 2 weeks, with evidence of objective functional improvement, total of up to 18 visits over 6-8 weeks. Elective/maintenance care; Not medically necessary. Recurrences/flare-ups; Need to re-evaluate treatment success, if RTW achieved then 1-2 visits every 4-6 months Page(s): 58-59.

**Decision rationale:** The claimant presented with chronic low back pain with radicular symptoms. Previous treatments include medications, injection, physical therapy, and chiropractic. According to the treating doctor progress report on 01/21/2014, the claimant has completed 12 chiropractic visits with "definite improvement" subjectively. However, objective findings remained the same, no changes in ROM, no change in medications, and the claimant continue to work full duties. Based on the guidelines cited, the request for additional 12 chiropractic treatments is not medically necessary due to no evidences of objective functional improvement with prior chiropractic therapy.