

<b>Case Number:</b>	CM15-0107017		
<b>Date Assigned:</b>	06/11/2015	<b>Date of Injury:</b>	09/18/1996
<b>Decision Date:</b>	07/13/2015	<b>UR Denial Date:</b>	05/06/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	06/03/2015

### 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 66 year old male, who sustained an industrial injury on 9/18/96. He reported initial complaints of bilateral upper extremities. The injured worker was diagnosed as having Achilles bursitis or tendinitis; affections of shoulder region; neck sprains/strains; lumbar region sprains/strains. Treatment to date has included physical therapy; chiropractic therapy; medications. Diagnostics included MRI right shoulder - recumbent supine (9/5/08); MRI left shoulder, recumbent/supine (9/5/08). Currently, the PR-2 notes dated 4/10/15 indicated the injured worker complains of continued back pain radiating to lower extremities with pain, paresthesia and numbness as well as right shoulder pain with decreased range of motion and strength. The physical examination shows spasm, tenderness, guarding in the paravertebral musculature of the lumbar spine with loss of range of motion. There is noted decreased sensation bilaterally in the S1 dermatomes with pain. The provider has requested authorization of Chiropractic treatment for the lumbar spine 3 times weekly for 4 weeks (12 sessions).

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Chiropractic treatment, Lumbar spine, 3 times wkly for 4 wks, 12 sessions: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Manual therapy and manipulation.

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

**Decision rationale:** The UR determination of 5/6/15 denied the request for additional Chiropractic care, 12 sessions, to manage the patient's lumbar spine citing CAMTUS Chronic Treatment Guidelines. The denial addressed the failure of the submitted supplemental report to provide objective clinical evidence of functional improvement following a prior course of Chiropractic care. The reviewed medical records do not report the medical necessity for additional treatment or comply with the prerequisites for additional care per CAMTUS Chronic Treatment Guidelines. Therefore, the request is not medically necessary.