

<b>Case Number:</b>	CM15-0012461		
<b>Date Assigned:</b>	01/30/2015	<b>Date of Injury:</b>	11/13/2013
<b>Decision Date:</b>	05/01/2015	<b>UR Denial Date:</b>	01/06/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	01/21/2015

### 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 47-year-old male who sustained an industrial injury on 11/13/13. The primary provider requested Chiropractic and physical therapy to manage reported cervical, thoracic and right knee deficits. The patient reported posterior neck, mid and lower back, bilateral knee and leg pain. Treatments to date include Chiropractic care and physical therapy along with medical management/medications. The medical provider reported on 11/18/14 the need for Chiropractic treatment, physical therapy, and low stress conditioning and aerobic exercises. On 01/01/15 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; 2 times a week for 4-6 weeks (cervical/thoracic/lumbar spine, left knee): Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Manipulation.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Manual therapy and manipulation.9294.2 Page(s): 58-59.

**Decision rationale:** The UR determination of 1/6/15 was reasonable, appropriate and consistent with referenced CA MTUS Chronic Treatment Guidelines. The treating providers request for both PT and Chiropractic care lacked a medical history of the number or prior applications of both Chiropractic care and physical therapy, both provided by the Chiropractic provider. There were no documents provided addressing the functional improvement derived from applied Chiropractic care or physical therapy, criteria for consideration of additional care per CMTUS Chronic Treatment Guidelines. "Functional improvement" means either a clinically significant improvement in activities of daily living or a reduction in work restrictions as measured during the history and physical exam, performed and documented as part of the evaluation and management visit. The request is not medically necessary.