

<b>Case Number:</b>	CM15-0042744		
<b>Date Assigned:</b>	03/12/2015	<b>Date of Injury:</b>	03/26/2013
<b>Decision Date:</b>	04/16/2015	<b>UR Denial Date:</b>	02/11/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	03/06/2015

### 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: New Jersey

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 45-year-old female who reported an injury on 03/26/2013. The mechanism of injury was not stated. The injured worker is diagnosed with low back pain with right sided radicular referral and right sacroiliac joint dysfunction with trochanteric bursitis. The injured worker presented on 01/19/2015 for a follow-up evaluation with complaints of pain in the right lower back and greater trochanteric area. Upon examination, there was tenderness at the right sacroiliac joint with a positive Gillet's sign, a positive compression test, and tenderness to palpation. Recommendations included chiropractic treatment. There was no Request for Authorization Form submitted for this review.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Chiropractic x 6:** Upheld

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

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

**Decision rationale:** California MTUS Guidelines recommend manual therapy and manipulation for chronic pain if caused by a musculoskeletal condition. Treatment is recommended as a therapeutic trial of 6 visits over 2 weeks. In this case, it is noted that the injured worker had been referred for a previous course of chiropractic therapy in 09/2014. Documentation of objective functional improvement following the initial trial was not provided. The request as submitted also failed to indicate a specific body part to be treated. Given the above, the request is not medically appropriate.