

<b>Case Number:</b>	CM15-0057404		
<b>Date Assigned:</b>	04/02/2015	<b>Date of Injury:</b>	04/02/2014
<b>Decision Date:</b>	05/07/2015	<b>UR Denial Date:</b>	03/03/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	03/26/2015

### 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

### 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 22 year old male, who sustained an industrial injury on 4/2/14. The injured worker was diagnosed as having lumbar disc bulge/protrusion, lumbar radiculitis, traumatic lumbar sprain/strain, cervical sprain/strain and thoracic sprain/strain. Treatment to date has included oral steroids, oral medications (NSAIDS) and activity restrictions. X-rays of cervical, thoracic and lumbar spine have been performed. (MRI) magnetic resonance imaging of lumbar spine was performed on 11/4/14. Currently, the injured worker complains of low back pain with occasional slight neck pain and slight mid back pain. Upon physical exam, restricted lumbar range of motion is noted with tenderness to palpation of T4-11 and L1-5 and slight tautness of parathoracic muscles. The current treatment plan consists of chiropractic adjustments to cervical, thoracic, lumbar and sacroiliac regions with electrical stimulation therapy.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Chiropractic therapy times eight for the back:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Manual Therapy.

**Decision rationale:** The claimant presented with persistent low back pain despite previous treatment with bracing, medications, chiropractic, and home exercises. Reviewed of the available medical records showed he has had 8 chiropractic visits authorized on 10/20/2014, and additional 6 visits on 12/17/2014. However, the claimant continues to have ongoing low back pain, pain management and injection were further recommended. Based on the guidelines cited, the request for additional 8 chiropractic treatments is not medical necessary due to lack of objective functional improvement from previous chiropractic therapy trial.