

<b>Case Number:</b>	CM15-0064718		
<b>Date Assigned:</b>	04/10/2015	<b>Date of Injury:</b>	12/04/2013
<b>Decision Date:</b>	05/11/2015	<b>UR Denial Date:</b>	03/09/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	04/06/2015

### 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: 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 40 year old female, who sustained an industrial injury on 12/04/2013. The initial diagnoses or complaints at time of injury were not clearly noted. On provider visit dated 01/28/2015 the injured worker has reported intermittent low back pain and stiffness with numbness and tingling. On examination of the lumbar spine was noted to have a decreased range of motion, tenderness to palpation of bilateral SI joints, coccyx, lumbar paravertebral muscles and sacrum. Muscle spasms were noted bilateral gluteus and lumbar paravertebral muscles. Straight leg raise causes pain. The diagnoses have included lumbar radiculopathy and lumbar sprain/strain. Treatment to date has included physical therapy and medication. The provider requested chiropractic treatment for the lumbar spine 1-2x/wk. x 4 wks.

### 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-1-2X/WK X4 WKS:**

Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines MANUAL THERAPY Page(s): 58-59.

**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 3/9/15 denied further Chiropractic care, 8 visits citing CA MTUS Chronic Treatment Guidelines. The reviewed medical records reported the patient completing 13 Chiropractic DOS prior to the request for 8 additional visits but failing to support the request for additional care by documenting objective clinical evidence of functional improvement, the criteria for additional care. The reviewed records did not provide clinical evidence of medical necessity for the requested additional care, 8 sessions or satisfy the criteria of the CA MTUS Chronic Treatment Guidelines by provided evidence of functional gain with prior care. Therefore is not medically necessary.