MAXIMUS Federal Services

| Case Number: | CM15-0070893 | | |
|---|---|---|---|
| Date Assigned: | 04/20/2015 | Date of Injury: | 10/17/2013 |
| Decision Date: | 05/19/2015 | UR Denial Date: | 03/13/2015 |
| Priority: | Standard | Application Received: | 04/14/2015 |

## 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, Minnesota
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 44 year old male, who sustained an industrial injury on 10/17/2013. He has reported injury to low back. The diagnoses have included protrusion 3mm left L4-5 with L4/L5 neural encroachment. Treatment to date has included medications, diagnostics, bracing, TENS (transcutaneous electrical nerve stimulation) unit, and physical therapy. Medications have included Hydrocodone, Cyclobenzaprine, and Pantoprazole. A progress note from the treating physician, 02/02/2015, documented a follow-up visit with the injured worker. Currently, the injured worker complains of lower back pain with left lower extremity symptoms; pain is rated at 6/10 on the visual analog scale; and pain level is markedly decreased, and activities of daily living are maintained, with medications. Objective findings included tenderness to the lumbar spine; lumbar range of motion is limited with pain; positive straight leg raise; and gait is slightly antalgic. The treatment plan has included the request for chiropractic tree times four for lumbar spine.

## IMR ISSUES, DECISIONS AND RATIONALES

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

**Chiropractic three times four for lumbar spine:** 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 9792.20-9792.26 Page(s): 58&59.

**Decision rationale:** According to the MTUS Chronic Pain guidelines above, manipulation of the low back is recommended as an option of 6 trial visits over 2 weeks, with evidence of objective functional improvement, total of up to 18 visits over 6-8 weeks. The doctor requested an initial treatment program of Chiropractic 3 times per week for 4 weeks for the lumbar spine. The request for Chiropractic visits is not according to the above guidelines and therefore the treatment is not medically necessary.