

<b>Case Number:</b>	CM14-0149880		
<b>Date Assigned:</b>	09/19/2014	<b>Date of Injury:</b>	08/10/2001
<b>Decision Date:</b>	10/22/2014	<b>UR Denial Date:</b>	08/21/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	09/15/2014

### 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. The expert reviewer is a licensed Chiropractor and is licensed to practice in California. 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

### 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 patient is a 53 year old male who was injured on 08/10/2001. The mechanism of injury is unknown. The patient has been treated conservatively with 24 sessions of physical therapy and 10 chiropractic visits. A progress report dated 08/13/2014 states the patient presented with exacerbation of symptoms. He reported left low back pain at the lumbosacral region with radiation to the left testicle and radiation down the left leg to the L5 dermatome to the dorsum of the left foot. He rated his pain as an 8/10. On exam, he has a 5 degree flexion thoracolumbar antalgia. He has a positive Minor's sign upon arising from a seated posture. Straight leg raise is positive on the right at 70 degrees and left is at 30 degrees with posterior leg pain to the ankle. Thoracolumbar range of motion was 50% restricted due to the pain. He has a left L5-S1 and sciatic notch with pain with palpation, and muscle guarding of the left paralumbar. The patient is diagnosed with lumbar intervertebral disc syndrome without myelopathy; lumbar radiculopathy and spasm. The patient was recommended chiropractic therapy to the low back. A prior utilization review dated 08/21/2014 states the request for Chiro 2x3, low back QTY: 6 visits as not medically necessary as there is a lack of documented evidence to support the request.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Chiro 2x3, low back QTY: 6 visits: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Manual therapy and manipulation. Decision based on Non-MTUS Citation Official Disability Guidelines-Treatment for Worker's Compensation

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines MANUAL THERAPY & MANIPULATION Page(s): 58-59. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low back, Manipulation

**Decision rationale:** The CA MTUS guide lines recommend the following: "Per The CA MTUS Guidelines,Low back: Recommended as an option Therapeutic care- Trial of 6 visits over 2 weeks with evidence of objective functional improvement, total of up to 18 visits over a 6-8 week.Elective/maintenance care - Not medically necessary, Recurrence/flare-ups- Need to re-evaluate treatment success, if RTW achieved then 1-2 visits every 4-6 months."Per the above guidelines, the request for 6 Chiropractic visits on a 2x week for 3 weeks basis, to treat a flare-up of this patient's original condition, would fall outside the guidelines for treatment of flare-ups and is therefore not medically necessary.