Case Number:	CM16-0232182		
Date Assigned:	01/04/2017	**Date of Injury:**	11/07/2016
Decision Date:	01/27/2017	**UR Denial Date:**	11/22/2016
Priority:	Standard	**Application Received:**	12/02/2016

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: Preventive Medicine, Occupational 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 53 year old male, who sustained an industrial injury on 11-7-16 and has been treated for left lower quadrant abdominal [pain, pelvic girdle muscle strain, lumbar strain and low back pain. On 11-9-16, the injured worker complained of left lower quadrant pain with limited, painful range of motion, the level of pain is rated 5 out of 10 and on 11-18-16, reports vast improvement in pain with chiropractic treatment. A physical exam was performed on 11-9-16 and revealed tenderness over the left lower abdomen and pain with hip flexion and on 11-18-16 and revealed limited, painful range of motion. Treatment to date has included chiropractic treatment (under private insurance and without documentation of objective functional improvement) and activity modifications. A request for authorization was submitted on 11-16-16 for chiropractic treatment 2 times a week for 3 weeks to the left groin and lumbar spine. On 11-22-16, request for chiropractic treatment 2 times a week for 3 weeks to the left groin and lumbar spine.

IMR ISSUES, DECISIONS AND RATIONALES

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

Referral to chiropractor for evaluation of low back pain and left groin pain, twice a week for 3 weeks: Upheld

Claims Administrator guideline: The Claims Administrator based their decision on recommendation(s) outside of the MTUS Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Chiropractic Guidelines.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2016, Section(s): Manual therapy & manipulation.

Decision rationale: MTUS recommends manual therapy and manipulation for chronic pain of the low back if caused by musculoskeletal conditions. Manual Therapy is widely used in the treatment of musculoskeletal pain. The intended goal or effect of Manual Medicine is the achievement of positive symptomatic or objective measurable gains in functional improvement that facilitate progression in the patient's therapeutic exercise program and return to productive activities. Manipulation is manual therapy that moves a joint beyond the physiologic range-of-motion but not beyond the anatomic range-of-motion. An initial trial of 6 visits over 2 weeks is recommended to establish objective functional improvement. A total up to 18 visits, over 6-8 weeks, may be appropriate with documentation of objective functional improvement. For a flare ups, or a recurrence of symptoms, re-evaluation of previous treatment success is necessary. If return to work is achieved, then 1-2 visits every 4-6 months is recommended. MTUS recommend that up to 18 visits over 6-8 weeks may be appropriate with documentation of objective functional improvement. Based on the documentation presented, there are no functional objective measures in the file presented, that show clinical progression and support necessity of continued treatment. Due to the lack of objective functional improvement, the request is not medically necessary.