Case Number:	CM16-0247660		
Date Assigned:	01/12/2017	**Date of Injury:**	10/16/2016
Decision Date:	02/02/2017	**UR Denial Date:**	11/30/2016
Priority:	Standard	**Application Received:**	12/27/2016

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 27 year old female, who sustained an industrial injury on 10-16-16 and has been treated for lumbar strain. On 11-1-16 and 11-7-16, the injured worker complained of low back pain with limited range of motion, on 11-15-16, complained of low back pain and paresthesias of the right thigh with radiation of back pain to the right thigh and on 11-22-16, complained of moderately severe low back pain with restricted range of motion. The injured worker is working modified duties. A physical exam was performed on 11-1-16 and 11-7-16 and revealed an abnormal, stiff gait, tenderness and spasms of the thoracolumbar spine and paravertebral musculature L1-L5 and restricted range of motion, on 11-15-16 and revealed tenderness of the thoracolumbar spine and paravertebral musculature without spasms and restricted range of motion and on 11-22-16 and revealed a slow, stiff gait, thoracolumbar and paravertebral musculature spasms and tenderness at L1-L5 and restricted range of motion. Treatment to date has included oral medications including Orphenadrine Citrate 100mg, Ketoprofen 50mg and Tylenol; 6 chiropractic treatments (without documentation of functional objective improvement) and activity modifications. The treatment plan for date of service 11-22-16 included a request for chiropractic therapy 3 times a week for 2 weeks. On 11-30-16, request for chiropractic therapy 3 times a week for 2 weeks was denied by utilization review.

IMR ISSUES, DECISIONS AND RATIONALES

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

Additional chiropractic three times a week for two weeks for the lumbar spine: Upheld

Claims Administrator guideline: Decision based on MTUS Low Back Complaints 2004. Decision based on Non-MTUS Citation Official Disability Guidelines, Low Back Chapter, Manipulation.

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.