

<b>Case Number:</b>	CM13-0006912		
<b>Date Assigned:</b>	05/21/2014	<b>Date of Injury:</b>	03/09/2012
<b>Decision Date:</b>	07/11/2014	<b>UR Denial Date:</b>	07/08/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	08/05/2013

### 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 licensed in Chiropractic 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 40-year-old female who was injured on 03/03/2012 while she was lifting boxes of applications overhead, twisted and she caught her heel while doing a pivot. She landed on her buttock and wrist breaking her fall. The treatment history includes physical therapy, acupuncture, chiropractic treatment, and a TENS unit. The diagnostic studies reviewed include an MRI of the lumbar spine dated 05/03/2012, which demonstrates right bilateral L5 spondylosis and Grade I L5-S1 spondylolisthesis, due to the fact that the disc is moderately desiccated, with posterior annular tear 3 mm annulus bulge. There is facet arthropathy noted with mild foraminal narrowing. An electromyography/nerve conduction study (EMG/NCS) dated 01/25/2013 was deemed normal. A clinic note dated 06/12/2013 states that the patient is symptomatic with low back pain, as well as in her right wrist. On exam, she has decreased lumbosacral range of motion. She has positive straight leg raise and motor strength is 5/5 in the lower extremities. There is local tenderness in the back and coccyx area. The patient is diagnosed with lumbosacral sprain/strain injury; myofascial pain syndrome; right hip sprain/strain injury; lumbosacral disc injury and coccydynia. Lumbar range of motion is limited exhibiting flexion at 35; extension at 15; rotation at 45 bilaterally and lateral bending at 45 bilaterally. Range of motion of the left hip, bilateral knees and ankles is within normal limits. Range of motion of the hips exhibits extension at 30 bilaterally; abduction at 50 bilaterally; adduction at 30 bilaterally; internal rotation at 35 bilaterally; and external rotation at 30 on the left and 50 on the right. The treatment and plan includes chiropractic treatment to decrease her pain. She is declining a cortisone injection at this time. These objective findings are the same as note dated 05/28/2013, when request was made for eight (8) sessions of chiropractic treatment. The prior utilization review dated 07/08/2013 states that the request for chirotherapy is non-certified as there is no documented functional improvement with therapy.

## IMR ISSUES, DECISIONS AND RATIONALES

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

**CHIROTHERAPY:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG).

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Manual Therapy and Manipulation Page(s): 58-59.

**Decision rationale:** The Chronic Pain Guidelines indicate that chiropractic treatment is recommended for chronic pain if caused by musculoskeletal conditions. In this case, this patient has chronic pain and has been treated with chiropractic treatment before. However, the guidelines indicate that further treatment may be recommended if there is functional improvement, decreasing pain and improving quality of life. The medical records submitted for review fail to document objective functional improvement. This patient continues to have lower back pain with decreased range of motion (ROM), despite prior sessions of chiropractic treatment. The objective findings from 05/28/2013 remained the same. The request for eight (8) visits of chiropractic treatment is not medically necessary, because it does not conform to the current guidelines.