

<b>Case Number:</b>	CM13-0031335		
<b>Date Assigned:</b>	12/27/2013	<b>Date of Injury:</b>	10/10/2008
<b>Decision Date:</b>	03/06/2014	<b>UR Denial Date:</b>	09/24/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/03/2013

### HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a Expert reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The Expert reviewer is licensed in 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:

This is a 57-year-old female who sustained injury on 09/02/2008. A note dated 04/22/2013 by [REDACTED] indicates that she was trying to set up a big bulletin board to put borders and putting away books/supplies. The next day, she developed pain in her lower back and headaches. After 3 weeks later, she reported severe pain in her neck, shoulder, mid back, lower back, and left arm. Her treatment history includes physical therapy, massage therapy, acupuncture, chiropractic treatment, and cervical ESI. She was working with modified work restrictions. Treatment plan was additional 4-6 sessions of physical therapy. Lumbar MRI dated 03/08/2013 showed, "Bilateral hypertrophic facet degenerative changes are seen at the L4-5 level. There is a 3 mm broad-based disk bulge encroaching into the inferior recess of bilateral neural foramina, causing no significant neural foraminal narrowing or canal stenosis. Bilateral hypertrophic facet degenerative changes are seen. Right-sided hypertrophic facet degenerative changes are noted at the L5-S1 level. There is no evidence of herniated nucleus pulposus, neural foraminal narrowing or canal stenosis. Disk desiccation at L4-L5." A note dated 04/16/2013 by [REDACTED] indicates that she presented with complaints of headaches, neck and upper back pain radiating to both upper extremities with numbness and tingling, lower back pain radiating to left lower extremity with numbness, tingling and weakness. On cervical spine exam, there was tenderness to palpation over paravertebral, trapezius, deltoid, and rhomboids. Negative axial compression and Spurling tests. Cervical Range Of Motion was normal but positive for pain and spasm. Reflexes 1+ in bilateral upper extremities. Motor strength was 5/5 in bilateral upper extremities. Sensory was decreased in bilateral C6 nerve root, otherwise normal. Shoulders, wrists and elbows ROM was normal. On lumbar spine exam, there was tenderness to palpation over lumbar paravertebral muscles with spasms and bilateral sacroiliac joint tenderness. Lumbar Range Of Motion was limited. Reflexes were 2+ in bilateral lower extremities. Motor strength

was 5/5 in bilateral lower extremities. Sensation decreased in bilateral calves, otherwise intact. He was diagnosed with cervical disc protrusion, cervical radiculopathy, and multilevel lumbar disc protrusions with radiculopathy. Treatment plan was repeat cervical ESI at C6-7. A note dated 08/15/2013 by [REDACTED] indicates she presented with complaints of continued neck and lower back pain radiating in upper and lower extremities with numbness and weakness. She also complained of headaches. The patient reported significant improvement in her neck and lower back pain and functioning with previous therapy sessions. She reported improvement of ROM and reduction in frequency and intensity of headaches. On exam, there was spasms, tenderness and guarding noted in cervical and lumbar spine with decreased Range Of Motion and decreased sensation in C6 dermatomes bilaterally. Treatment recommendation was 12 sessions of chiropractic therapy for cervical and lumbar spine to reduce her pain and increase Range Of Motion and functioning. The current review is for chiropractic care 3x4 weeks for cervical and lumbar spine.

### **IMR ISSUES, DECISIONS AND RATIONALES**

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

**Chiropractic treatment 3 times a week for 4 weeks to Cervical Lumbar Spine:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Manual Therapy & Manipulation Page(s): 58-60.

**Decision rationale:** As per Chronic Pain Medical Treatment Guidelines, an initial trial of 6 visits over 2 weeks for chiropractic care is recommended with evidence of objective functional improvement for total of 18 visits over 6-8 weeks. A provider note dated 08/15/2013 noted that the patient reported subjective improvement in her neck and lower back pain and functioning with previous therapy sessions. She was previously treated with chiropractic care, but there is no documentation provided regarding objective functional improvement. Therefore, the request for chiropractic care 3x4 weeks for cervical lumbar spine is non-certified.