

<b>Case Number:</b>	CM13-0039236		
<b>Date Assigned:</b>	01/15/2014	<b>Date of Injury:</b>	07/12/2001
<b>Decision Date:</b>	03/25/2014	<b>UR Denial Date:</b>	09/03/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/04/2013

### 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 Care 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 54 year old male who sustained injuries to his thoracic and lumbar regions on 07/12/2001. Symptoms reported per PTP's report of 8/14/13 are "Frequent (51% to 75% of awake time) pain in the bilateral mid back with bilateral muscle spasm in the mid back extending to the lower back." Records explaining the mechanism of injury do not exist in the notes provided. Chiropractic care treatment records are provided only showing the patient has been treated with medications, chiropractic care, heat, massage and performed self-home exercises. It is unknown if other conservative and/or non-conservative treatments have been provided. There are no reports nor mention of any diagnostic studies in the records provided. Diagnoses assigned by the PTP are thoracic sprain/strain, myofascitis, lumbar sprain/strain, low back pain and radiculitis. The PTP is requesting 4 chiropractic sessions to the thoracic and lumbar spine at 2 per week for 2 weeks.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Chiropractic treatment 2 wk x 2 wks- 1 month:** Upheld

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

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

**Decision rationale:** The Expert Reviewer's decision rationale: This patient suffers from mid back and lower back injuries, per the records provided. UR has certified 3 sessions of chiropractic care on 11/19/13. The date of this request for 4 session of chiropractic care is 8/14/13. PR2 reports provided from 10/5/12 to 11/8/13 do not demonstrate objective measurable functional improvements per MTUS definitions. The PTP's only ROM measurements appear in the report of 8/14/13. The pain intensity remains 8/10 for the thoracolumbar region throughout reports provided from 8/14/13 to 11/8/13 and 6/10 from 10/5/12 to 5/1//13. MTUS-Definitions page 1 defines functional improvement as a "clinically significant improvement in activities of daily living or a reduction in work restrictions as measured during the history and physical exam, performed and documented as part of the evaluation and management visit billed under the Official Medical Fee Schedule (OMFS) pursuant to Sections 9789.10-9789.11; and a reduction in the dependency on continued medical treatment." Chronic Pain Medical Treatment Guidelines, Manipulation and Manual Therapy Section p.58-59 state that Manual therapy and manipulation is "recommended for chronic pain if caused by musculoskeletal conditions. 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." The same section also states that manipulation is "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 6-8 weeks. The ODG Low Back-Lumbar & Thoracic chapter, Manipulation Section recommends for recurrences/flare-ups : "Need to re-evaluate treatment success, if RTW achieved then 1-2 visits every 4-6 months when there is evidence of significant functional limitations on exam that are likely to respond to repeat chiropractic care." Considering the lack of objective functional improvements per MTUS Guidelines referenced in this paragraph I find that the request for 4 chiropractic sessions to not be medically necessary and appropriate.