

<b>Case Number:</b>	CM13-0044670		
<b>Date Assigned:</b>	12/27/2013	<b>Date of Injury:</b>	08/24/2010
<b>Decision Date:</b>	03/05/2014	<b>UR Denial Date:</b>	10/22/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/31/2013

### HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Anesthesiology, has a subspecialty in Acupuncture and Pain Management 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 physician 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 35-year-old injured worker with date of injury 8/24/10 with related low back pain rated 2/10 per report dated 11/12/13. The patient is diagnosed with lumbar disc herniation without myelopathy; lumbar myalgia; lumbar myospasm; left-sided lumbar neuritis/radiculitis. The patient has attended approximately 30 physical therapy and 18 chiropractic visits since surgery. The patient is status post a lumbar spine fusion at L4-S1 on 11/30/12. Per 11/12/13 note, X-rays of the lumbar spine (date unknown) demonstrated fusion and intact hardware, which is in good position. Per 9/3/13 progress report, "According to the patient, there is no need for creams or medications, and we will continue to treat the patient as per Qualified Medical Evaluator". The date of UR decision was 10/23/13.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Chiropractic care, three times per week for four weeks:** 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): 58-59.

**Decision rationale:** The Physician Reviewer's decision rationale: According to Chronic Pain Medical Treatment Guidelines, manual therapy is "Recommended for chronic pain 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." Additionally, "Low back: 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. Elective/maintenance care - Not medically necessary. Recurrences/flare-ups - Need to reevaluate treatment success, if RTW (return to work) is achieved then 1-2 visits every 4-6 months." The documentation submitted for review do not indicate evidence of functional improvement or RTW. It is noted that the injured worker has already attended 18 chiropractic sessions. Further chiropractic treatment is not indicated. Additionally, according to the 9/3/13 progress report, the injured worker related his pain at a level of 2 on a scale of 1 to 10. The request for Chiropractic care, three times per week for four weeks, is not medically necessary or appropriate.

**Lumbar x-ray:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303.

**Decision rationale:** The Physician Reviewer's decision rationale: Per ACOEM guidelines p303, " Lumbar spine x rays should not be recommended in patients with low back pain in the absence of red flags for serious spinal pathology, even if the pain has persisted for at least six weeks. However, it may be appropriate when the physician believes it would aid in patient management." The documentation submitted for review do not comment on the need for lumbar x-ray to aid in patient management, nor do they note the presence of red flags for serious spinal pathology. The request for a lumbar x-ray is not medically necessary or appropriate.