

<b>Case Number:</b>	CM14-0004513		
<b>Date Assigned:</b>	02/05/2014	<b>Date of Injury:</b>	01/02/2003
<b>Decision Date:</b>	06/20/2014	<b>UR Denial Date:</b>	01/09/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	01/13/2014

### 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 Chiropractics 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 67-year old female, [REDACTED], with an injury date of 01/02/2013 when she slipped and fell down a stairway, twisting the right ankle and injuring her lumbar spine at the same time. The medical encounter note of 06/25/2013 reports the patient to permanent and stationary and working full time per her chiropractor. The patient underwent AME on 07/30/2013 and was diagnosed with right lumbosacral strain and radiculopathy myofascial pain syndrome, right ankle pain, status post right arthroscopy and right peroneal tendon repair on 12/20/2009, and right superficial peroneal neuropathy as evidenced by EMG/NCS results. The medical progress report of 08/13/2013 reports the patient presented for treatment of lower backache which had decreased since the last visit, she was status post transforaminal epidural steroid injection in July with pain score reduced from 8/10 to 1-2/10. An examination on 08/13/2013 reported normal thoracic spine movement, without midline shift, without paraspinal muscle tenderness, increased tone or appreciable trigger point. An examination on 08/13/2013 reported with lumbar spine ROM decreased, with palpable paravertebral muscle spasm and mild tenderness, heel and toe walk normal, SLR negative, and motor examination with patient moving all extremities well, light touch sensation decreased over medial foot, first toe and lateral knee, and the patient was diagnosed with lumbar radiculopathy, lumbar DDD, low back pain, and muscle spasm. On 08/13/2013, there was a recommendation for chiropractic therapy at a frequency of 1-2 times per week as needed. The medical progress report of 12/31/2013 reported 100% pain relief of radiating pain (radicular pain) now 4/10, still with relief from 07/25/2013 TFESI, and her activity levels had increased and since her last visit was continuing to work. The 12/31/2013 thoracic exam was essentially negative, and lumbar ranges of motion were limited with palpable lumbar paravertebral muscle spasms and mild tenderness noted, with negative SLR, she moved all extremities well, and light touch sensation was decreased over the medial

foot, first toe and lateral knee. She was diagnosed with lumbar radiculopathy, lumbar DDD, low back pain and muscle spasm. There was a recommendation for ongoing chiropractic care at a frequency of two times per month. No chiropractic clinical documentation was provided for this review.

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

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

#### **CONTINUED CHIROPRACTIC SESSIONS (2 TIMES A MONTH, FOR 12 SESSIONS)(2X6): Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines MANUAL THERAPY AND MANIPULATION.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines MANUAL THERAPY & MANIPULATION Page(s): 58-59.

**Decision rationale:** The request for additional chiropractic treatment sessions at a frequency of 2 times per month for 6 months is not supported to be medically necessary. The chiropractor did not submit documentation of patient history, comparative measured subjective or objective clinical data, treatment plans with measurable treatment goals, or clinical chart note records. Although the chiropractor did not provide any documentation, per medical encounter note of 06/25/2013 the patient was permanent and stationary and working full time per her chiropractor; therefore, it is known the patient had treated with chiropractic care prior to 06/25/2013. On 08/13/2013, there was a recommendation for chiropractic therapy at a frequency of 1-2 times per week as needed, and on 12/31/2013 there was a recommendation for ongoing chiropractic care at a frequency of two times per month. California MTUS (Chronic Pain Medical Treatment Guidelines), pages 58-59, supports a 6-visit trial of manual therapy and manipulation over 2 weeks in the treatment of some chronic pain complaints if caused by musculoskeletal conditions. With evidence of objective functional improvement with care during the 6-visit treatment trial, a total of up to 18 visits over 6-8 weeks may be considered. Elective/maintenance care is not medically necessary. Relative to recurrences/flare-ups, there is the need to evaluate prior treatment success, if RTW (return to work) then 1-2 visits every 4-6 months. There was no documentation to provide evidence of objective functional improvement with chiropractic care rendered or evidence of a recurrence/flare-up, and elective/maintenance care is not supported to be medically necessary. Therefore, the request for additional chiropractic sessions is not supported to be medically necessary.