

<b>Case Number:</b>	CM14-0103952		
<b>Date Assigned:</b>	07/30/2014	<b>Date of Injury:</b>	12/07/2007
<b>Decision Date:</b>	12/02/2014	<b>UR Denial Date:</b>	06/17/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	07/07/2014

### 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 Board Certified in Chiropractic, has a subspecialty in Acupuncture 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 injured worker is a 34 year old female who reported neck and low back pain from injury sustained on 12/07/07. Mechanism of injury was not documented in the provided medical records. There were no diagnostic imaging reports. Patient is diagnosed with lumbar sprain; myalgia and myositis and displacement of intervertebral disc. Patient has been treated with medication, physical therapy and chiropractic. Per medical notes dated 03/12/14, patient complains of persistent neck pain that is rated 10/10 which radiates to bilateral arms. She complains of bilateral shoulder pain rated at 10/10 which is frequent and radiates to her fingers. She has low back pain rated at 10/10. Examination revealed decreased range of motion and tenderness to palpation of the injured body parts. Treatment plan includes continuing physical therapy and Chiropractic. Per medical notes dated 05/15/14, patient complains of constant neck pain rated 10/10 which has worsened, low back pain rated 9/10 which has remained the same, and bilateral shoulder pain rated 9-10/10. She complains of migraines, sleeping problems. Medication decreases her pain from 10/10 to 7/10. Examination revealed decreased range of motion and tenderness to palpation. Provider requested additional 2X6 chiropractic sessions for low back pain. Medical reports reveal little evidence of significant changes or improvement in findings, revealing a patient who has not achieved significant objective functional improvement to warrant additional treatment.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Chiropractic 2 x per week x 6 weeks, Lumbar Spine: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Manual Therapy and manipulation. Decision based on Non-MTUS Citation Official Disability Guidelines, Low Back Chapter, Manipulation, Chiropractic Guidelines

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

**Decision rationale:** Per MTUS, Chronic Pain medical treatment guidelines, manual therapy and manipulation. Page 58-59 states "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 objectively measureable gain in functional improvement that facilitates progression in the patient's therapeutic exercise program and return to productive activities". 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 and elective/ maintenance care- not medically necessary. Reoccurrences/ flare-ups- need to re-evaluate treatment success, if RTW achieved then 1-2 visits every 4-6 months and treatment parameters from state guidelines. A) Time of procedure effect: 4-6 treatments. B) Frequency 1-2 times per week the first 2 weeks as indicated by the severity of the condition. Treatment may continue at 1 treatment per week for the next 6 weeks. C) Maximum duration: 8 weeks. At 8 weeks patient should be re-evaluated. Care beyond 8 weeks may be indicated for certain chronic pain patients in whom manipulation has been helpful in improving function, decreasing pain and improving quality of life. Treatment beyond 4-6 visits should be documented with objective improvement in function". Patient has had prior chiropractic treatments; however, clinical notes fail to document any functional improvement with prior care. Provider requested additional 2X6 chiropractic sessions for lumbar spine. Medical reports reveal little evidence of significant changes or improvement in findings, revealing a patient who has not achieved significant objective functional improvement to warrant additional treatment. Per guidelines, functional improvement means either a clinically significant improvement in activities of daily living or a reduction in work restrictions as measured during the history and physical exam. Requested visits exceed the quantity supported by cited guidelines. Per review of evidence and guidelines, 2X6 Chiropractic visits are not medically necessary.