

<b>Case Number:</b>	CM14-0108929		
<b>Date Assigned:</b>	08/01/2014	<b>Date of Injury:</b>	11/08/2013
<b>Decision Date:</b>	10/17/2014	<b>UR Denial Date:</b>	07/07/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	07/14/2014

### 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 Chiropractic and 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 48 year old female who reported low back pain from injury sustained on 11/08/13 during the normal course of her employment. MRI of the lumbar spine revealed mild canal stenosis with narrowing of bilateral recesses at L4-5 with contact of bilateral central L5 nerve root in the lateral recesses by 2mm concentric bulge with associated annular fissuring; mild osteoarthritis in right L4-5 facet joints and mild osteoarthritis of L5-S1 facet joints. Patient is diagnosed with thoracic spine sprain/strain, degenerative joint disease and herniated nucleus pulposus; lumbar sprain/strain, degenerative joint disease and herniated nucleus pulposus; myofascial pain. Per medical notes dated 03/27/14, the degenerative finding in the lumbar spine has been becoming worse over time. She is not capable of any form of activity. Per medical notes dated 04/29/14, the lumbosacral symptoms are interfering with all forms of daily activities and daily life. The radiculopathy is tremendously greater on the right than the left. Provider is requesting additional 8 chiropractic sessions. Patient has had Chiropractic treatments. Patient hasn't had any long term symptomatic or functional relief with Chiropractic care. 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 treatment #8 to lumbar spine:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines, 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 guideline - Manual therapy and manipulation Page 58-59. "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 sin functional improvement that facilitate 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. 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. 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 with symptomatic relief; however, clinical notes fail to document any functional improvement with prior care. 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. Per review of evidence and guidelines, 8 Chiropractic visits are not medically necessary.