

<b>Case Number:</b>	CM14-0151739		
<b>Date Assigned:</b>	10/01/2014	<b>Date of Injury:</b>	12/16/1996
<b>Decision Date:</b>	10/29/2014	<b>UR Denial Date:</b>	08/21/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	09/17/2014

### 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 & 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 72 year old male who reported low back pain from injury sustained on 12/16/1996. Mechanism of injury was not documented in provided medical records. There were no diagnostic imaging reports. Patient is diagnosed with non-allopathic sacral lesion, Sacroiliac sprain/strain and lumbago. Patient has been treated with medication and chiropractic. Most medical notes were handwritten and moderately illegible. Per medical notes dated 08/28/14, patient complains of low back pain with no change in condition. Pain is dull, throbbing and moderate in nature. Pain is rated at 7/10. Pain is aggravated with movement, standing and walking and is alleviated with chiropractic. Examination revealed increased tone of right lumbosacral paraspinal muscles and decreased lumbar extension with pain. Per medical notes dated 09/25/14, patient complains of bilateral low back pain with no change. Pain is moderate, dull and throbbing and is rated at 7-8/10. There is no assessment in the provided medical records of objective functional benefit with prior 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:

**A retrospective request for chiropractic therapy with a date of service with 7/31/2014:**

Upheld

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**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 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 sin 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. The treatment parameters from state guidelines include, 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. Per medical notes dated 08/28/14, patient complains of low back pain with no change in condition. 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, retrospective Chiropractic visit dated 07/31/14 is not medically necessary.