

<b>Case Number:</b>	CM14-0067680		
<b>Date Assigned:</b>	07/11/2014	<b>Date of Injury:</b>	11/11/1986
<b>Decision Date:</b>	09/19/2014	<b>UR Denial Date:</b>	04/30/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	05/12/2014

### 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 Physical Medicine and Rehabilitation, 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 69-year-old female who reported an injury, the mechanism of which is not known, on 11/11/1986. On 04/21/2014, her diagnoses included lumbosacral spondylosis without myelopathy, back pain, radiculitis, lumbar radiculopathy, degenerative joint disease of the spine, lumbar degenerative disc disease, sciatica, lumbar disc disorder without myelopathy, and coccygodynia. Upon examination, specialized tests for the lumbar spine, including the straight leg raising test, prone rectus femoris test, reverse straight leg raising test, Waddell's sign, and left and right facet loading Kemp's tests, were all negative. There was moderate tenderness noted at the bilateral gluteal regions, the bilateral lower lumbar paraspinal muscles, and the lower sacrum and coccyx. Her primary complaint was increased lower back pain due to a fall 2 weeks prior to the visit. She rated her back pain at 9/10. The fall resulted in a fracture to her coccyx. The treatment plan included requests for radiofrequency ablations. There was no rationale or Request for Authorization included in this worker's chart.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Lumbar MRI:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Page(s): 303-304.  
Decision based on Non-MTUS Citation Official Disability Guidelines: Low Back - Lumbar and Thoracic MRI's.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303-305.

**Decision rationale:** ACOEM Guidelines recommend that relying solely on imaging studies to evaluate the source of low back pain and related symptoms carries a significant risk of diagnostic confusion, including false positive test results, because of the possibility of identifying a finding that was present before symptoms began and, therefore, had no temporal association with the symptoms. False positive results have been found in up to 50% of those over the age of 40. It was noted in the documentation that this worker had an MRI of the lumbar spine on 12/03/2012, the results of which were similar to the previous MRI of 03/12/2010. There was no rationale or justification for a repeat MRI. The clinical information submitted failed to meet the evidence based guidelines for a repeat MRI. Therefore, the request is not medically necessary.

**Chiropractic 1 x 6 visits - consist of a combination of massage and manipulation for the lumbar spine:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Manual therapy & manipulation, Massage Therapy, Physical Therapy.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Manual therapy & manipulation Page(s): 58-60.

**Decision rationale:** MTUS Guidelines recommend chiropractic treatment for chronic pain if caused by musculoskeletal conditions. 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 a patient's therapeutic exercise program and return to productive activities. It is recommended as an option for low back complaints. A trial of 6 visits over 2 weeks is recommended with evidence of objective functional improvement to be seen within the 2 week period. Elective/maintenance care, is not medically necessary. For recurrences or flare-ups the need to re-evaluate treatment success is seen. If the return to work is achieved then 1 visit to 2 visits can be scheduled every 4 months to 6 months. The request for 1 chiropractic visit per week for 6 weeks exceeds the recommendations in the guidelines. The need for chiropractic treatment was not clearly demonstrated in the submitted documentation. Therefore, the request is not medically necessary.