

<b>Case Number:</b>	CM14-0121508		
<b>Date Assigned:</b>	09/16/2014	<b>Date of Injury:</b>	06/04/2003
<b>Decision Date:</b>	07/17/2015	<b>UR Denial Date:</b>	07/24/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	08/01/2014

### 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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:

State(s) of Licensure: California

Certification(s)/Specialty: Chiropractic

### 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(n) 50 year old male, who sustained an industrial injury on 6/4/03. He reported pain on his left side after he fell backwards off a ladder. The injured worker was diagnosed as having lumbar strain, lower extremity radiculitis with a 3mm disc bulge at L5-S1 and left-sided sacroiliac joint sprain. Treatment to date has included physical therapy, a lumbar epidural injection x 2, Norco, chiropractic treatments and a lumbar CT. As of the PR2 dated 7/11/14, the injured worker reports pain in the left sacroiliac joint has improved for weeks following the rhizotomy but the pain has returned over the past few months. Objective findings include a positive Faber's test and decreased range of motion. The treating physician requested chiropractic treatments (retrospective x 3) to the lumbar spine. The carrier's UR department has modified the request and approved 1 session retrospectively.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Retrospective 3 Chiropractic manipulation treatments DOS: 2/11/14, 3/5/14, and 4/1/14.:**  
Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Neck and upper Back (Acute and chronic).

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Manual Therapy & Manipulation/MTUS Definitions Page(s): 58/1. Decision based on Non-MTUS Citation ODG Low Back Chapter, Manipulation Section.

**Decision rationale:** The patient has received chiropractic care for his lumbar spine injury in the past. Three sessions have been provided recently. The request is for their authorization retrospectively. The UR review company has authorized 1 of the 3 sessions. One past chiropractic progress report dated May 2014 is present in the materials provided and was reviewed. The total number of chiropractic sessions provided to date is unknown and not specified in the records provided for review. Regardless, the one PR2 report submitted for review does not show objective functional improvement with past chiropractic care rendered, per MTUS definitions. The MTUS Chronic Pain Medical Treatment Guidelines recommends additional care with evidence of objective functional improvement. The ODG Low Back Chapter also recommends 1-2 additional chiropractic care sessions over 4-6 months with evidence of objective functional improvement. The MTUS-Definitions page 1 defines functional improvement as a "clinically significant improvement in activities of daily living or a reduction in work restrictions as measured during the history and physical exam, performed and documented as part of the evaluation and management visit billed under the Official Medical Fee Schedule (OMFS) pursuant to Sections 9789.10-9789.11; and a reduction in the dependency on continued medical treatment." There has been no objective functional improvements with the care in the past per the treating chiropractor's progress notes reviewed. The UR department has reviewed the request and approved 1 retrospective session. I find that the 3 additional retrospective chiropractic sessions requested to the lumbar spine are not medically necessary and appropriate.