

<b>Case Number:</b>	CM14-0192098		
<b>Date Assigned:</b>	11/25/2014	<b>Date of Injury:</b>	06/27/2012
<b>Decision Date:</b>	01/14/2015	<b>UR Denial Date:</b>	10/14/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	11/17/2014

### 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 Preventive Medicine, has a subspecialty in Occupational Medicine and is licensed to practice in Iowa. 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:

This is a 41 year old patient with date of injury of 06/27/2012. Medical records indicate the patient is undergoing treatment for multiple annular tears suggestive of herniated disc along L5-S1, symptomatic, sacroiliac arthropathy, lumbar radiculopathy and lumbar degenerative disc disease. Subjective complaints include right sided lower back pain radiating posteriorly down right leg. Objective findings include antalgic gait, tenderness along SI joint, forward flexion 20 degrees which induces right radiculopathy down the SI joint posteriorly to the right gluteal region and down right leg; muscles of low back are guarded and tender to palpation, extension limited to 10 degrees; straight leg raise positive on the right, decreased Achilles reflex at on the right, left 2+4 and sensory abnormalities along the S1 nerve root. An MRI on 08/20/2014 showed a mild posterior disc bulge at L4-5 and mild ligamentum flavum thickening at L3-4. The treatment has consisted of right SI joint injection, EMG/NCV, Citalopram, Omeprazole, Diclofenac, Gabapentin, Flexeril and compound topical cream. The utilization review determination was rendered on 10/14/2014 recommending non-certification of Chiropractic 3xwk X 3wks Lumbar Spine.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Chiropractic 3xwk X 3wks Lumbar Spine:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Manual Therapy & Manipulation Page(s): 58-60.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Manual Therapy & Manipulation Page(s): 58-60. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back - Lumbar & Thoracic (Acute & Chronic), Chiropractic, Manipulation

**Decision rationale:** The ODG recommends chiropractic treatment as an option for acute low back pain, but additionally clarifies that "medical evidence shows good outcomes from the use of manipulation in acute low back pain without radiculopathy (but also not necessarily any better than outcomes from other recommended treatments). If manipulation has not resulted in functional improvement in the first one or two weeks, it should be stopped and the patient reevaluated." Additionally, the MTUS states "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. Recurrences/flare-ups - Need to reevaluate treatment success, if RTW achieved then 1-2 visits every 4-6 months." Medical documents indicate that patient has undergone 9 chiropractic sessions. The treating provider has not demonstrated evidence of objective and measurable functional improvement during or after the trial of therapeutic care to warrant continued treatment at this time. As such, the request for Chiropractic 3xwk X 3wks Lumbar Spine is not medically necessary.