

<b>Case Number:</b>	CM15-0185954		
<b>Date Assigned:</b>	10/02/2015	<b>Date of Injury:</b>	11/05/1999
<b>Decision Date:</b>	11/16/2015	<b>UR Denial Date:</b>	09/08/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	09/21/2015

### 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) 70 year old male, who sustained an industrial injury on 11-5-99. The injured worker was diagnosed as having lumbosacral strain and right lower extremity neuralgia-paresthesia. Medical records (11-10-14 through 5-11-15) indicated baseline pain levels were "slight to minimal" and pain flares up with activities of daily living. The physical exam (3-6-15 through 6-8-15) revealed a positive Kemp's test, a positive straight leg raise test on the right at 20 degrees and 5 out of 5 lumbar spasms. As of the PR2 dated 7-7-15, the injured worker reports constant pain in his lower back and right leg numbness. Objective findings include a positive Kemp's test, lumbar flexion approximately 18 inches away from the floor and extension 10 out of 25 degrees. Treatment to date has included chiropractic treatments and exercise at the gym. The treating physician requested a Utilization Review for retrospective review for 1 visit to include: evaluation/management, specific chiropractic manipulation, electrical muscle stimulation, intersegmental traction, manual therapy for control of insidious flare-up of low back pain, and prescription of medications, date of service: 08/10/15. The Utilization Review dated 9-8-15, modified the request for retrospective review for 1 visit to include all requested items except traction and electrical muscle stimulation.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Retrospective review for 1 visit to include: evaluation/management, specific chiropractic manipulation, electrical muscle stimulation, intersegmental traction, manual therapy for control of insidious flare-up of low back pain, and prescription of medications, date of service: 08/10/15: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back - Lumbar & Thoracic (Acute & Chronic).

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Manual therapy & manipulation. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back/Manipulation, Traction/EMS.

**Decision rationale:** The patient has received chiropractic care for his lumbar spine injury in the past. The request in this case is for manual traction, EMS, E/M, manipulation, manual therapy, and medications. All requested items to be provided within this one session were approved except traction and EMS. The past chiropractic treatment notes are present in the materials provided and were reviewed. The total number of chiropractic sessions provided to date are unknown and not specified in the records provided for review. The treatment records submitted for review do 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." Due to evidence of objective functional improvement, the retrospective session of chiropractic care was approved by UR. However, the request has several elements within it that were examined and non-certification was provided for two of those items: Traction and EMS. The MTUS and ODG do not recommend traction or EMS. I find that the traction and EMS requested to the lumbar spine to not be medically necessary and appropriate.