

<b>Case Number:</b>	CM15-0191135		
<b>Date Assigned:</b>	10/05/2015	<b>Date of Injury:</b>	09/01/1995
<b>Decision Date:</b>	11/10/2015	<b>UR Denial Date:</b>	08/31/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	09/29/2015

### 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 58-year-old male, with a reported date of injury of 09-01-1995. The diagnoses include lumbar radiculitis. Treatments and evaluation to date have included Gabapentin, Trazodone, Norco, and Tramadol. The diagnostic studies to date have included a urine drug screen on 08-29-2015, which was positive for methamphetamine, marijuana, cotinine, and Tramadol. The progress report dated 07-30-2015 indicates that the injured worker complained of left cervicobrachial pain and radicular symptoms. He reported numbness in his left fourth and fifth fingers. The injured worker continued to experience occasional flares in his left shoulder and lower back pain. The injured worker rated his neck and low back pain 3-7 out of 10. The treating physician indicated that the injured worker reported substantial symptomatic relief of his left shoulder and lower back chronic pain symptoms after attending chiropractic therapy. The medical records did not include chiropractic therapy reports. The treating physician recommended 6 chiropractic sessions. The physical examination showed tenderness over the right bicipital tendon groove and posterior lateral subacromion; limited range of motion of the bilateral arms; and diminished sensation in the left C7 and bilateral L4-5 and L5-S1. The injured worker's work status was not indicated. The request for authorization was dated 07-30-2015. The treating physician requested chiropractic treatment two times a week for three weeks for the lumbar spine. On 08-31-2015, Utilization Review (UR) non-certified the request for chiropractic treatment two times a week for three weeks for the lumbar spine.

## IMR ISSUES, DECISIONS AND RATIONALES

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

**Chiropractic 2 times a week for 3 weeks, lumbar spine:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009.

**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.

**Decision rationale:** The patient has received chiropractic care for his lumbar spine injury in the past. The date of injury is 9/1/1995. The past chiropractic treatment notes are not present in the materials provided. The total number of chiropractic sessions provided to date are unknown and not specified in the records provided for review. Regardless, the treatment records submitted for review do 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 have been no objective functional improvements with the care in the past per the PTP's progress notes reviewed. The 6 requested sessions far exceed the MTUS recommended number of 1-2 sessions over 4-6 months. I find that the 6 additional chiropractic sessions requested to the lumbar spine is not medically necessary and appropriate.