

<b>Case Number:</b>	CM15-0194284		
<b>Date Assigned:</b>	10/08/2015	<b>Date of Injury:</b>	12/02/2008
<b>Decision Date:</b>	12/03/2015	<b>UR Denial Date:</b>	09/24/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/02/2015

### 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: Chiropractor

### 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 40 year old male, who sustained an industrial injury on 12-02-2008. A review of the medical records indicates that the injured worker (IW) is undergoing treatment for lumbar strain and sprain, lumbosacral neuritis, and thoracic strain and sprain. Medical records (04-29-2015 to 09-17-2015) indicate a flare-up of low back pain, and mid back pain radiating to the thoracolumbar junction. Pain levels were increased from 4 to 7 out of 10 on a visual analog scale (VAS) for the low back, and 4 out of 10 for the mid back. Records did not address activity levels or level of function. Per the treating physician's progress report (PR), the IW has returned to work with restrictions. The physical exam, dated 09-17-2015, revealed slight pain at the C3-4 bilaterally and mild pain at C4-5 and C5-6 bilaterally upon palpation of the vertebral units and paraspinal muscles, slightly increased range of motion (ROM) in the cervical spine, moderate pain upon palpation of the vertebral units and paraspinal muscles of the left L1-2 and L2-3 regions, moderate pain in the left pelvic region, restricted ROM in the lumbar spine, and positive left straight leg raises. Relevant treatments have included work restrictions, and medications. It was noted that the IW was seeing a chiropractor on a regular basis; however, there were no treatment notes or notes regarding such treatment results. The request for authorization (09-17-2015) shows that the following services were requested: 1 chiropractic re-exam, and 4 chiropractic visits to include spinal manipulation 3-4 regions, therapeutic exercise, and mechanical traction. The original utilization review (09-24-2015) non-certified the request for 1 chiropractic re-exam, and 4 chiropractic visits to include spinal manipulation 3-4 regions, therapeutic exercise, and mechanical traction.

## IMR ISSUES, DECISIONS AND RATIONALES

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

**4 chiropractic visits to include spinal manipulation 3-4 regions, therapeutic exercise, and mechanical traction:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Neck and Upper Back Complaints 2004, Section(s): Initial Care, and Low Back Complaints 2004, Section(s): Physical Methods, and Chronic Pain Medical Treatment 2009, Section(s): Exercise, Manual therapy & manipulation.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Manual therapy & manipulation.

**Decision rationale:** The medical necessity for the requested 4 additional chiropractic treatments was not established. This claimant has received treatment on what appears to be a one-time per week basis for some time with no evidence of improvement. The claimant has followed up with his orthopedic surgeon, [REDACTED], who opined on his periodic evaluations that the claimant's condition had not improved. Continued treatment at one time per week for an ongoing period of time suggests more maintenance or elective type care. The MTUS chronic pain treatment guidelines give the following recommendations: "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." Therefore, the requested continued treatment at one time per week is not medically necessary and was not established.

**1 chiropractic re-exam:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Neck and Upper Back Complaints 2004, Section(s): Initial Care, and Low Back Complaints 2004, Section(s): Physical Methods, and Chronic Pain Medical Treatment 2009, Section(s): Exercise, Manual therapy & manipulation.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Manual therapy & manipulation.

**Decision rationale:** The medical necessity for the requested reevaluation was not established. The determination was that additional chiropractic was elective or maintenance in nature and not supported. Therefore, the need for a follow-up evaluation was not established. The request is not medically necessary.