

<b>Case Number:</b>	CM15-0032356		
<b>Date Assigned:</b>	02/25/2015	<b>Date of Injury:</b>	07/12/2012
<b>Decision Date:</b>	04/07/2015	<b>UR Denial Date:</b>	01/27/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	02/20/2015

### 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 56 year old male, who sustained an industrial injury on CT-1985 through 7/12/12. He has reported back injury. The diagnoses have included lumbar radiculitis, sacroiliitis, and degeneration of lumbar or lumbosacral disc, lumbalgia and sciatica. Treatment to date has included physical therapy, chiropractic treatments, pain medicines and heat/ice therapy. (MRI) magnetic resonance imaging of lumbar spine performed on 4/19/13 revealed 3mm right paracentral protrusion and annular tear with minimal attenuation in the anterior epidural fat and bilateral sub articular recess without central or foraminal stenosis at L4-5 and L3-4 disc space is a central annular fissure without central or foraminal stenosis. Currently, the injured worker complains of severe low back pain with radiation to the right hip, right knee and right lower back. Physical exam dated 12/19/14 revealed motion palpable fixation, muscle spasm, restricted motion, stiffness and tenderness in left T8, right T11, bilateral T9, T12, L3-5, S1 and SI. On 1/27/15 Utilization Review non-certified additional chiropractic treatments to include physical therapy and DRX-9000 treatment times 12 visits, noting he had completed 20 sessions of chiropractic care however there is no documentation of objective improvement with previous treatment, functional deficits and a statement identifying why an independent home exercise program would be insufficient to address any remaining functional deficits. The MTUS, ACOEM Guidelines, was cited. On 2/20/15, the injured worker submitted an application for IMR for review of chiropractic treatments to include physical therapy and DRX-9000 treatment times 12 visits.

## IMR ISSUES, DECISIONS AND RATIONALES

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

**12 chiropractic treatments, to include physical therapy and DRX-9000 treatment:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 173, Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines, Chiropractic Guidelines/DRX.

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

**Decision rationale:** The patient has received prior chiropractic care for his injuries. The MTUS Chronic Pain Medical Treatment Guidelines recommends additional manipulative care with evidence of objective functional improvement. The ODG Low Back Chapter for recurrences /flare-ups states: "Need to re-evaluate treatment success, if RTW achieved then 1-2 visits every 4-6 months when there is evidence of significant functional limitations on exam that are likely to respond to repeat chiropractic care." 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." The PTP describes some Improvements with treatment but no objective measurements are listed. The ODG does not recommend the use of automated flexion-distraction machines like DRX-9000. The records provided by the primary treating physician do not show objective functional improvements with ongoing chiropractic treatments rendered. The treating chiropractor's records are not available for review. I find that the 12 additional chiropractic sessions to include physical therapy and DRX-9000 requested to the lumbar spine to not be medically necessary and appropriate.