

<b>Case Number:</b>	CM15-0033829		
<b>Date Assigned:</b>	02/27/2015	<b>Date of Injury:</b>	04/30/2010
<b>Decision Date:</b>	04/07/2015	<b>UR Denial Date:</b>	01/28/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	02/23/2015

### 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: New York, Pennsylvania, Washington  
 Certification(s)/Specialty: Internal Medicine, Geriatric Medicine

### 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 60 year old male, who sustained an industrial injury on 4/30/10. He has reported low back injury from cumulative injuries working as a firefighter. The diagnoses have included severe degenerative scoliosis and retrolisthesis. Treatment to date has included medications, physical therapy, diagnostics, and chiropractic sessions. Currently, per physician orthopedic evaluation dated 8/15/14, the injured worker complains of low back pain issues rated 3/10 pain with stiffness. The pain is achy and dull and worse in the morning. Chiropractic treatment has been helping to keep his pain manageable. The current medications included Ibuprofen, Indomethaci and proloptic ointments. Physical exam revealed positive muscle pain and stiffness, joint pain, numbness and tingling. The back shows no listing. The lumbar spine x-ray revealed degenerative lumbar scoliosis with retrolisthesis. Treatment was for chiropractic sessions as this has controlled his symptoms in the past to keep him from having major back surgery. Therapy sessions were noted. Work status was permanent and stationary. On 1/28/15 Utilization Review non-certified a request for Chiropractic therapy 1 time per month for 12 months, noting the (MTUS) Medical Treatment Utilization Schedule chronic pain guidelines were cited.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Chiropractic therapy 1 time per month for 12 months:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines 9792.20 ? 9792.26 Page(s): 58-59.

**Decision rationale:** Per the guidelines, chiropractic or manual therapy is recommended for chronic pain if caused by musculoskeletal conditions. The intended goal or effect of manual medicine is the achievement of positive symptomatic or objective measurable gains in functional improvement that facilitate progression in the patient's therapeutic exercise program and return to productive activities. Maximum duration is said to be 8 weeks. The records do not indicate that the worker is not able to return to productive activities or that the worker is participating in an ongoing exercise program to which the chiropractic cares would be an adjunct. The records do not support the medical necessity of additional sessions of chiropractic therapy.