

<b>Case Number:</b>	CM14-0161773		
<b>Date Assigned:</b>	10/07/2014	<b>Date of Injury:</b>	03/17/2014
<b>Decision Date:</b>	11/13/2014	<b>UR Denial Date:</b>	09/16/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/02/2014

### 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. The expert reviewer is Board Certified in Chiropractic and Acupuncture, and is licensed to practice in California. 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

### 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 53 year old female who reported low back pain from injury sustained on 03/17/14; while stacking groceries into a customer cart, when the customer had moved behind her, in avoiding the member she twisted suddenly to change direction in order to avoid hitting the customer. MRI of the lumbar spine revealed minimal disc bulges at L2-3 and L3-4 and degenerative facet disease at L4-5. Patient is diagnosed with lumbar sprain with radicular complains. Patient has been treated with medication, physical therapy, acupuncture and Chiropractic. Per medical notes dated 07/09/14, patient complains of low back pain with radiation to the left thigh. She notices a heavy pressure of the left side of the low back. She continues to have spasms in the left leg. Examination revealed increased tone and tenderness about the paralumbar musculature with tenderness about the paralumbar musculature with tenderness at midline thoraco-lumbar junction and over the level of L5-S1 facets and right greater sciatic notch. Per medical notes dated 08/06/14, patient complains of low back pain with radiation to the left thigh. She notices a heavy pressure on the left side of low back. She continues to have spasms in the left leg. Provider requested additional 8 Chiropractic treatments. Patient hasn't had any long term symptomatic or functional relief with Chiropractic care. Medical reports reveal little evidence of significant changes or improvement in findings, revealing a patient who has not achieved significant objective functional improvement to warrant additional treatment.

### IMR ISSUES, DECISIONS AND RATIONALES

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

## **8 sessions of chiropractic therapy for treatment of lumbar spine: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Manual Therapy and Manipulation Page(s): 58-59.

**Decision rationale:** Per MTUS- Chronic Pain medical Treatment Guideline - Manual therapy and manipulation, pages 58-59-"Recommended for chronic pain if caused by musculoskeletal conditions. Manual therapy is widely used in the treatment of musculoskeletal pain. The intended goal or effect of manual medicine is the achievement of positive symptomatic or objectively measureable gain in functional improvement that facilitates progression in the patient's therapeutic exercise program and return to productive activities". 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 is not medically necessary. Reoccurrences/ flare-ups- need to re-evaluate treatment success, if RTW achieved then 1-2 visits every 4-6 months. Treatment parameters from state guidelines: A) Time of procedure effect: 4-6 treatments. B) Frequency 1-2 times per week the first 2 weeks as indicated by the severity of the condition. Treatment may continue at 1 treatment per week for the next 6 weeks. C) Maximum duration: 8 weeks. At 8 weeks patient should be re-evaluated. Care beyond 8 weeks may be indicated for certain chronic pain patients in whom manipulation has been helpful in improving function, decreasing pain and improving quality of life. Treatment beyond 4-6 visits should be documented with objective improvement in function". Patient has had prior chiropractic treatments with symptomatic relief; however, clinical notes fail to document any functional improvement with prior care. Patient hasn't had any long term symptomatic or functional relief with Chiropractic care. Medical reports reveal little evidence of significant changes or improvement in findings, revealing a patient who has not achieved significant objective functional improvement to warrant additional treatment. Per guidelines, functional improvement means either a clinically significant improvement in activities of daily living or a reduction in work restrictions as measured during the history and physical exam. Per review of evidence and guidelines, the request for an additional 8 Chiropractic visits are not medically necessary.