

<b>Case Number:</b>	CM14-0176117		
<b>Date Assigned:</b>	10/29/2014	<b>Date of Injury:</b>	07/18/2013
<b>Decision Date:</b>	12/05/2014	<b>UR Denial Date:</b>	10/17/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/23/2014

### 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 a licensed Doctor of Chiropractic, has a subspecialty in 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 39 year old male who reported low back and bilateral knee pain from injury sustained on 07/18/13 due to slip and fall. MRI of the left knee dated 04/24/14 revealed complex tear of the middle segment posterior horn medial meniscus and subluxation of patella. MRI of the right knee revealed complex tear involving the mid-segment posterior horn medial meniscus associated with a meniscal cyst posterior. MRI of the lumbar spine revealed disc desiccation and 3mm broad based posterior disc protrusion L5-S1; mild hypertrophic changes of facet on the right. Patient is diagnosed with musculoligamentous sprain/strain of lumbar spine, right knee and left knee; right knee medial meniscal tear; left knee meniscus tear. Patient has been treated with medication, physical therapy and Chiropractic. Per medical notes dated 09/05/14, patient complains of low back pain rated at 7/10, bilateral knee pain rated 9-10/10. Examination revealed +4TTP of bilateral knee and lumbar spine. Per medical notes dated 09/12/14, patient complains of low back pain rated at 7/10, bilateral knee pain rated 9-10/10. Pain increases with weight bearing. Provider requested 12 Chiropractic sessions for lumbar spine. Per utilization review, patient has had prior Chiropractic sessions. 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:

**Twelve (12) chiropractic therapy sessions for the lumbar spine: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Manual therapy & manipulation Page(s): 58-59.

**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 Page 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 facilitate progression in the patient's therapeutic exercise program and returns 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- 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; however, clinical notes fail to document any functional improvement with prior care. Provider requested additional 2X6 chiropractic sessions for lumbar spine. 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. Requested visits exceed the quantity supported by cited guidelines. Per review of evidence and guidelines, 2 X 6 Chiropractic visits are not medically necessary.