

<b>Case Number:</b>	CM15-0016226		
<b>Date Assigned:</b>	02/04/2015	<b>Date of Injury:</b>	03/05/2002
<b>Decision Date:</b>	03/24/2015	<b>UR Denial Date:</b>	01/26/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	01/28/2015

### 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 41 year old female, who sustained an industrial injury on 03/05/2002. The diagnoses have included displacement of cervical and lumbar discs. Noted treatments to date have included chiropractic treatment. No MRI report noted in received medical records. In a progress note dated 01/09/2015, the injured worker presented with complaints of neck and lower back pain. The treating physician reported treating injured worker to relieve pain, decrease muscle spasms, and improve activities of daily living. Utilization Review determination on 01/26/2015 non-certified the request for Chiropractic Care 2 x 4 for Cervical Spine and Chiropractic Care 2 x 4 for Lumbar Spine citing Medical Treatment Utilization Schedule.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Chiropractic therapy x 8 for the cervical spine:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Page(s): 98-99.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Manual Therapy and Manipulation Page(s): 58. Decision based on Non-MTUS Citation Neck & Upper Back Chapter MTUS Definitions

**Decision rationale:** The patient has received prior chiropractic care for her injuries. The MTUS Chronic Pain Medical Treatment Guidelines recommends additional manipulative care for the cervical spine with evidence of objective functional improvement. The ODG Neck & Upper 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 range of motion is documented to be "WNL" within normal limits with ongoing care and pain intensities are constant as documented by the treating chiropractor. The records provided by the primary treating chiropractor do not show objective functional improvements with ongoing chiropractic treatments rendered. I find that the 8 chiropractic sessions requested to the cervical spine to not be medically necessary and appropriate.

**Chiropractic therapy x 8 for the lumbar spine:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Page(s): 98-99.

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

**Decision rationale:** The patient has received prior chiropractic care for her injuries. The MTUS Chronic Pain Medical Treatment Guidelines recommends additional manipulative care to the lower back 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 range of motion is documented to be "WNL" within normal limits with ongoing care and pain intensities are constant as documented by the treating chiropractor. The records provided by the primary treating chiropractor do not show objective functional improvements with ongoing chiropractic treatments rendered. I find that the 8

chiropractic sessions requested to the lumbar spine to not be medically necessary and appropriate.