

<b>Case Number:</b>	CM15-0125795		
<b>Date Assigned:</b>	07/10/2015	<b>Date of Injury:</b>	08/27/1997
<b>Decision Date:</b>	08/11/2015	<b>UR Denial Date:</b>	06/10/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	06/29/2015

### 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 46-year-old male who sustained a work related injury August 27, 1997. According to a primary treating physician's progress report, dated June 4, 2015, the injured worker presented with complaints of gradual onset of moderate lumbar pain with burning and tingling in the right lateral thigh to the knee, increasing over the past two weeks. He reports the symptoms are worsened by prolonged standing, sitting, and driving. He cannot take pain relievers due to severe gastritis. Objective findings included; lumbar range of motion diminished 60-70% flexion, and right lateral flexion. There is a positive Kemp's test, moderate L4-S1 pain, positive straight leg raise 50 degrees on the right, producing right lumbar pain radiating to the right hip and knee. There is moderate to severe spasm right lumbar spine paravertebral muscles, right hip and thigh. Reflexes are +2/+2, sensory decreased L2, L3 dermatomes right, strength is normal in lower extremities. Documentation revealed previous flare-ups of lumbar spine pain in January 2015 and August 2014, and bilateral rotator cuff syndrome October, 2014, all treated with spinal manipulation/extraspinal manipulation. Diagnoses are lumbar radiculopathy; lumbosacral segmental dysfunction, myalgia. At issue is the request for authorization for 6 additional chiropractic therapies with massage to the lumbar spine.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Additional chiropractic therapy with massage 2 times a week for 3 weeks: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Manual therapy & manipulation.

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

**Decision rationale:** The patient has received chiropractic care for his lumbar spine injury in the past. The past chiropractic treatment notes are present in the materials provided and were reviewed. The total numbers of chiropractic sessions provided to date are unknown and not specified in the records provided for review. Regardless, the treatment records submitted for review do not show objective functional improvement with past chiropractic care rendered, per MTUS definitions. The MTUS Chronic Pain Medical Treatment Guidelines recommends additional care with evidence of objective functional improvement. The ODG Low Back Chapter also recommends 1-2 additional chiropractic care sessions over 4-6 months with evidence of objective functional improvement. 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." There have been no objective functional improvements with the care in the past per the treating chiropractor's progress notes reviewed. I find that the 6 additional chiropractic sessions requested to the lumbar spine to not be medically necessary and appropriate.