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DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:
Chiropractic therapy to cervical, thoracic and lumbar spine three times a week XX (97110, 97530, 98940, 97035, 97032)

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:
Chiropractor

REVIEW OUTCOME:
Upon independent review, the reviewer finds that the previous adverse determination/adverse determinations should be:
☒ Upheld (Agree)
Provide a description of the review outcome that clearly states whether medical necessity exists for each of the health care services in dispute.

PATIENT CLINICAL HISTORY [SUMMARY]:
The patient is a XXXX who was injured on XXXX, while XXXX.

On XXXX, the patient was seen by XXXX. The patient complained of flare-up of lower back pain due to cold front. XXXX continued to experience persistent, throbbing aching lower back pain and stiffness in XXXX lower back. XXXX reported sitting and standing intolerance. There was weakness in XXXX lower back and legs. XXXX reported weakness and instability in XXXX lower extremities, worse in the left leg. XXXX reported twinges of sharp pain in XXXX lower back with coughing and sneezing. The pain level was 8+. History was notable for prior surgery x2 – 360 lumbar fusion in XXXX and a revision surgery in XXXX. The patient also complained of progressive weakness, radiating pain, numbness, tingling sensation, night pain and night cramps down the bilateral legs, worse in the left leg. The patient was unable to perform activities of daily living (ADLs). XXXX reported difficulty with weight bearing to the left side due to left knee and leg pain and weakness. XXXX reported difficulty with sitting, standing, walking, climbing up and down stairs, bending, squatting, and lifting heavy objects. The pain level was 8+. The patient complained of unrelenting consequential left knee pain due to altered gait secondary to two times back surgery and weakness in XXXX legs. XXXX reported constant aching, stiffness, buckling, popping, cramps and sharp pain along with give way weakness. On exam, the lumbar spine range of motion (ROM) was flexion 45 degrees and extension 10 degrees. There was lumbar midline tenderness with spasms in the paravertebral bilaterally. There was positive straight leg raising (SLR) test at 35 degrees on the left side. Valsalva maneuver reproduced build up discomfort in the lumbar region. The motor strength was 4/5 in the right lower extremity and 3/5 in the left lower extremity and 4/5 in the left extensor hallucis longus (EHL). Sensory examination to pinprick analysis revealed decreased sensation along L4, L5 and S1. The gait was antalgic. The left knee ROM was flexion 85 degrees and extension 0 degrees. There was tenderness in the infrapatellar region and lateral compartments. The McMurray testing could not be performed due to guarding. There was crepitation under the patella on ROM. The diagnoses were lumbar sprain, failed back syndrome and left

knee sprain. The patient was prescribed a lumbar corset and a knee brace. XXXX was advised a brief course of advanced therapy and rehab three times a week for four weeks. A left knee MRI was ordered.

On XXXX, XXXX provided a prescription for therapy to the lower back and neck. The proposed modalities included therapeutic exercises, myofascial release, ultrasound and electrical muscle stimulation.

On XXXX, the patient was seen at XXXX. The patient reported lower back pain, mid back pain and neck pain. The lower back pain was progressively getting worse. The intensity of pain was moderate-to-severe. It occurred 50-80% of the time. The pain was rated as 6. It was aggravated by bending forward, bending back, bending to the left, bending to the right, twisting left and twisting right. The mid back pain was continuous, 80-100% of the time. The pain level was rated as 4. It was located posterolaterally on both sides. It was aggravated by bending forward, bending back, bending to the left and bending to the right. The neck pain was getting progressively worse. The pain intensity was 50-80% of the time. The pain level was 5. It was located posterolaterally on both sides. It was aggravated by bending forward, bending back, bending to the left, bending to the right, twisting left, twisting right and coughing. On exam, the lumbar spine had tenderness to digital palpation and muscle-tendon on both sides. There was muscle hypertonicity on both sides. There was edema and swelling on both sides. The ROM was reduced in all planes with pain. There was pain on lateral bending bilaterally, flexion, extension and rotation bilaterally. The muscle testing of the lumbar flexors was grade 2, lumbar extensors was grade 2, right lateral flexors was grade 1, and left lateral flexors was grade 3. The thoracic spine had tenderness, muscle hypertonicity and muscle spasm on both sides. There was edema and swelling on the right side. The ROM was moderately reduced with pain. The cervical spine had tenderness, muscle hypertonicity and muscle spasm on both sides. The cervical ROM was moderately reduced with pain. There was pain on extension, lateral bending bilaterally and flexion. The following orthopedic signs were positive on the lumbar spine: Kemp's on the right, Lasegue's on the right, Braggard's on the right, and SLR test. The patellar reflex was 1+ on the right and 2+ on the left. The Achilles reflex was 1+ on the right and 2+ on the left. The pinwheel testing of the L4 and L5 dermatome on the right demonstrated decreased sensation when compared to the opposite side. The diagnoses were sprain of the lumbar spine, sprain of thoracic spine, left-sided sciatica, other muscle spasm, sprain of cervical spine, lumbosacral intervertebral disc disorders with radiculopathy, and cervical disc disorder with radiculopathy. The patient was treated with chiropractic adjustment, therapeutic activities and therapeutic exercises. The recommendations included chiropractic adjustment to the low back, sacrum and both sacroiliac (SI) joints, lower mid back, mid back; therapeutic adjustments for the next 10 visits; and neuromuscular reeducation to the mid back, lower mid back, low back and sacrum.

A precertification request was submitted on XXXX.

On an unknown date, XXXX., performed a utilization review. The request for chiropractic treatment three times a week for four weeks to the cervical, thoracic, and lumbar spine (97110, 97530, 98940, 97035, and 97032) was denied based on the following rationale: "*On* XXXX, *the patient sustained a work-related injury; however, the mechanism of injury is unclear. Per the evaluation on* XXXX *from* XXXX, *the patient complained of frequent moderate to severe lower back pain rated 6/10, continuous moderate mid back pain rated 4/10, and frequent moderate neck pain rated 5/10. Upon examination, the cervical ranges of motion were moderately reduced with pain on extension, bilateral lateral bending, and flexion. The thoracic ranges of motion were moderately reduced with pain. The lumbar ranges of motion were reduced in all ranges with pain on bilateral lateral bending, flexion, extension, and bilateral rotation. Muscle testing showed that the lumbar flexors and lumbar extensors were grade 2, the right lateral flexors were grade 1, and the left lateral flexors were grade 3. General weakness was noted in the lower extremities. The upper extremity reflexes were +2 bilaterally (normal). The left patellar and Achilles reflexes were + 1 (hypoactive). Decreased sensation was noted in the right L4 and*

right L5 dermatomes. The following orthopedic tests were positive: Kemp's on the right, Lasegue's test on the right, Braggard's sign on the right, and straight leg raise test on the right. Muscle hypertonicity, muscle spasm, edema, and swelling was noted in the cervical, thoracic, and lumbar spine. This is a request for chiropractic (XX) for the cervical, thoracic, and lumbar spine (97110, 97530, 98940, 97035, 97032). According to XXXX*, the patient has had two failed back surgeries in* XXXX. XXXX *said that the patient saw an orthopedic, and XXXX wants the patient to try therapy to see if it helps.* XXXX *confirmed that the patient has been at clinical MMI for the initial injury; however, XXXX was not sure of the MMI date and the whole person impairment. There is no evidence of an intervening event or exceptional factors to support the initiation of any supervised care versus a home exercise program at this point in XXXX recovery given the date of injury and the natural course of healing. The guidelines do not support the use of every available treatment modality without taking into account what is needed for cure. Finally, the guidelines also do not support the use of every available treatment modality as an entitlement. The request for chiropractic (XX) for the cervical, thoracic, and lumbar spine (97110, 97530, 98940, 97035, 97032) is not supported."*

On XXXX, XXXX, performed a reconsideration and upheld the denial for chiropractic three times a week for XX to the cervical, thoracic and lumbar spine (97110, 97530, 98940, 97035 and 97032). Rationale: "*Per evidence-based guidelines, the recommended chiropractic/manipulation for a mild cervical strain is up to 6 visits over XX weeks while the recommended visits for the lumbar/thoracic is for a total of up to 18 visits over XX weeks with evidence of objective functional improvement if acute. In this case, it was reported that the patient had prior chiropractic visits/sessions. However, clarification is needed as to how many sessions the patient was able to complete given the chronicity of the injury. Furthermore, clinical objective findings were also limited to validate the efficacy specific from the chiropractic sessions rendered. The guidelines still do not support the use of every available treatment modality without taking into account what is needed for cure. Telephone contact was established with the provider. XXXX confirmed the reason for the request was based on the orthopedic surgeon recommendation before attempting any procedures. The patient was last seen by* XXXX *in* XXXX *as noted above. The provider confirmed there are no intervening events and the note on* XXXX *finds no objective functional changes from baseline residual deficits and chronic pain complaints that would be expected to improve with additional chiropractic treatment. Medical necessity is not supported. The prior non-certification is upheld."*

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS, AND CONCLUSIONS USED TO SUPPORT THE DECISION:

At this juncture of care, the condition would be considered to be a chronic condition. There is no indication that there has been any new injury or aggravation to XXXX original injury. No outcome assessments were performed for determining the results for the treatment prescribed.

Based on ODG Guidelines, the treatment for XXXX original injury has been completed and the claimant reached maximum medical improvement. Further care will not give significant improvement to XXXX medical condition. Although, chiropractic care can be included in the treatment received the patient has passed the point of care in which it would be considered to be medically necessary.

There is no basis for medical necessity for the treatment of the cervical, thoracic and lumbar spine based on the examination and the history/outcome information given.

☐ Medically Necessary
☒ Not Medically Necessary

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

☒ **ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES**