

<b>Case Number:</b>	CM13-0040121		
<b>Date Assigned:</b>	01/03/2014	<b>Date of Injury:</b>	03/19/2013
<b>Decision Date:</b>	03/28/2014	<b>UR Denial Date:</b>	09/26/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	09/26/2013

### HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Physical Medicine and Rehabilitation, 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 physician 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:

According to the records made available for review, this is a 39-year-old with a 3/19/13 date of injury. At the time of request for authorization for Additional chiropractic services to the lumbar spine 3x6 and Additional physical therapy treatment to the lumbar spine 3x6, there is documentation of subjective (low back pain) and objective (tenderness to palpation in the left and right lumbar and sacroiliac areas) findings, current diagnoses (lumbosacral sprain/strain), and treatment to date (17 chiropractic physiotherapy sessions and medication). Regarding the requested Additional chiropractic services to the lumbar spine 3x6, there is no documentation of objective improvement with previous treatment. In addition, the requested number of sessions, in addition to the sessions already completed, would exceed guidelines. Regarding the requested Additional physical therapy treatment to the lumbar spine 3x6, there is no documentation of objective improvement with previous treatment and exceptional factors.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**ADDITIONAL CHIROPRACTIC SERVICES TO THE LUMBAR SPINE 3X6:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Manual Therapy & Manipulation Section Page(s): s 58-60.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): s 298-299, Chronic Pain Treatment Guidelines Manual Therapy & Manipulation Section Page(s): 58.

**Decision rationale:** The Low Back Complaints Chapter of the ACOEM Practice Guidelines identifies documentation of objective improvement with previous treatment, functional deficits, functional goals, and a statement identifying why an independent home exercise program would be insufficient to address any remaining functional deficits, as criteria necessary to support the medical necessity of additional chiropractic treatment. In addition, the Chronic Pain Medical Treatment Guidelines supports a total of up to 18 visits over 6-8 weeks. Within the medical information available for review, there is documentation of diagnoses of lumbosacral sprain/strain. In addition, there is documentation of 17 chiropractic physiotherapy treatments completed to date, functional deficits, and functional goals. However, there is no documentation of objective improvement with previous treatment. In addition, the requested number of sessions, in addition to the sessions already completed, would exceed guidelines. The request for additional chiropractic services to the lumbar spine, three times per week for six weeks, is not medically necessary or appropriate.

**ADDITIONAL PT TREATMENT TO THE LUMBAR SPINE 3X6:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Manual Therapy & Manipulation Section Page(s): s 58-60.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Pain, Suffering, and the Restoration of Function Chapter (ACOEM Practice Guidelines, 2nd Edition (2004), Chapter 6) page 114 as well as the Official Disability Guidelines (ODG), Low Back Chapter, Physical therapy (PT) Section

**Decision rationale:** The Pain, Suffering, and the Restoration of Function Chapter of the ACOEM Practice Guidelines identifies the importance of a time-limited treatment plan with clearly defined functional goals, with frequent assessment and modification of the treatment plan based upon the patient's progress in meeting those goals, as criteria necessary to support the medical necessity of additional physical therapy. The ODG recommends a limited course of physical therapy for patients with a diagnosis of cervical spine sprain/strain not to exceed ten sessions over 8 weeks, and documentation of exceptional factors when treatment duration and/or number of visits exceeds the guidelines, as criteria necessary to support the medical necessity of additional physical therapy. Within the medical information available for review, there is documentation of diagnoses of lumbosacral sprain/strain. In addition, there is documentation of 17 chiropractic physiotherapy treatments completed to date, which exceeds guidelines, functional deficits, and functional goals. Furthermore, there is no documentation of objective improvement with previous treatment and exceptional factors. The request for additional physical therapy treatments to the lumbar spine, three times per week for six weeks, is not medically necessary or appropriate.

