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| <b>Case Number:</b>   | CM13-0061762 |                              |            |
| <b>Date Assigned:</b> | 12/30/2013   | <b>Date of Injury:</b>       | 04/17/2013 |
| <b>Decision Date:</b> | 05/07/2014   | <b>UR Denial Date:</b>       | 11/25/2013 |
| <b>Priority:</b>      | Standard     | <b>Application Received:</b> | 12/05/2013 |

### 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 Board Certified in Physical Medicine and Rehabilitation, has a subspecialty in Pain Medicine and is licensed to practice in Texas. 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 patient is a 23-year-old male who reported an injury on 04/17/2013; the mechanism of injury was a fall from a tree. The patient fell from the tree and twisted his back. The patient has been treated with medications, activity modification, a lumbar spine back brace, acupuncture, shockwave therapy, and chiropractic care. As of 04/19/2013 the patient attended 2/6 treatments. The clinical note dated 12/09/2013 noted the patient reported burning, radicular low back pain, muscle spasms, and pain radiation down to the lower extremities. The patient reported his pain was constant and moderate to severe, rated 6-7/10. The patient's pain was aggravated by activities of daily living such as getting dressed and performing personal hygiene. The patient's lumbar spine range of motion was assessed and documented as follows; 25 degrees of flexion, 10 degrees of extension, 15 degrees of left lateral flexion, 20 degrees of right lateral flexion, 20 degrees of left rotation, and 10 degrees of right rotation. The patient had decreased strength in the L2, L3, L4, L5, and S1 myotomes bilaterally. A request for chiropractic manipulation was submitted on 11/04/2013, the rationale for the request was unclear. A request for shockwave therapy for the lumbar spine was submitted on 01/08/2014 due to the patient's subjective complaints and objective findings.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**CHIROPRACTIC SESSIONS THREE (3) TIMES A WEEK FOR SIX (6) WEEKS FOR THE LUMBAR SPINE:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Manual Therapy Section Page(s): 58-59.

**Decision rationale:** The California MTUS states manual therapy is widely used in the treatment of musculoskeletal pain and low back pain; recommended as an option. Therapeutic care: trial of 6 visits over 2 weeks with evidence of objective functional improvement; total up to 18 visits over 6 to 8 weeks; elective maintenance care not medically necessary; frequency of 1 to 2 times a week for the first 2 weeks is indicated by severity of condition. Treatment may continue once a week for the next 6 weeks; maximum duration 8 weeks. At week 8, the patient should be re-evaluated. If chiropractic treatment is going to be effective, there should be some outward sign of subjective or objective improvement within the first 6 visits. Manual therapy is not recommended for ankle and foot; low back is recommended as an option. The request for chiropractic manipulation for the lumbar spine 3 times a week for 6 weeks is a total of 18 visits. Within the provided documentation it appears the patient previously underwent chiropractic care; however, it was unclear how many sessions of chiropractic care the patient attended. The efficacy of the prior chiropractic care was unclear within the provided documentation. Additionally, the request for 18 sessions of chiropractic care would exceed the guideline recommendations. As such, the request for chiropractic manipulation for lumbar spine, 3x6 is non-certified.

**SIX (6) SESSIONS OF SHOCKWAVE THERAPY FOR THE LUMBAR SPINE:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Shoulder Chapter, Shock Wave Therapy Section.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Shoulder Chapter, Shock Wave Therapy Section.

**Decision rationale:** The Official Disability Guidelines state shockwave therapy is not recommended. The request for shockwave therapy for the lumbar spine for 6 sessions does not meet guidelines set by Official Disability Guidelines. The patient was noted to have undergone prior sessions of shockwave therapy; however, the efficacy of the treatment was unclear. Additionally, it was unclear how many sessions of shockwave therapy the patient previously underwent. As such, the request for shockwave therapy for the lumbar spine 6 sessions is non-certified.