

<b>Case Number:</b>	CM13-0069365		
<b>Date Assigned:</b>	01/03/2014	<b>Date of Injury:</b>	09/03/2013
<b>Decision Date:</b>	06/04/2014	<b>UR Denial Date:</b>	11/25/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	12/20/2013

### 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 Rehabilitation and Pain Medicine and is licensed to practice in Texas and Ohio. 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 injured worker is a 41 year old male that reported a back injury from a forklift collision on 09/03/2013. On the clinical notes from 11/07/2013 the worker reported intermittent low back pain, lumbar range of motion was 90% of normal, trunk flexion 60/60, trunk extension 15/25, and deep tendon reflexes 2+. Within the same note is the request for the treatment being reviewed. However, there is not an official RFA in the submitted documents. Physical therapy notes on 09/10/2013 reported all lumbar range of motion within normal limits. The last physical therapy note on 10/21/2013 released the worker to full duty and no permanent disability necessary.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**PHYSIOTHERAPY THREE TIMES A WEEK FOR FOUR WEEKS TO THE LUMBAR SPINE:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines PHYSICAL MEDICINE Page(s): 98-99. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back-Lumbar & Thoracic (Acute & Chronic), Physical Therapy.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines PHYSICAL MEDICINE Page(s): 98-99.

**Decision rationale:** The injured worker has received therapy and at a minimum was at 90% function and in the physical therapy notes had full range of motion in his lumbar spine. The CA MTUS recommends physical therapy be used for functional deficits and treatment be no longer than 9-10 visits over 8 weeks. The request is asking for 12 visits total which exceeds the guidelines and the worker has already been discharged from physical therapy. Thus, the request for Physiotherapy is not medically necessary.

**CHIROPRACTIC THERAPY TWICE A WEEK FOR FOUR WEEKS TO THE LUMBAR SPINE:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Manual Therapy and Manipulation Page(s): 58. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back-Lumbar & Thoracic (Acute & Chronic), Physical Therapy.

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

**Decision rationale:** The worker has received therapy and at a minimum was at 90% function and in the physical therapy notes had full range of motion in his lumbar spine. The CA MTUS recommends manual therapy be used for functional deficits and treatment be no longer than 6 visits over 4 weeks as a trial before additional visits are recommended. The request is asking for 12 visits total which exceeds the guidelines and the worker has already been discharged from physical therapy. Thus, the request for Chiropractic Therapy is not medically necessary.

**UPDATE LUMBAR X-RAYS:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303-305.

**Decision rationale:** The worker has received therapy and at a minimum was at 90% function and in the physical therapy notes had full range of motion in his lumbar spine. The ACOEM guidelines recommend the lumbar spine x rays should not be recommended in patients with low back pain in the absence of red flags for serious spinal pathology, even if the pain has persisted for at least six weeks. In addition, Relying solely on imaging studies to evaluate the source of low back and related symptoms carries a significant risk of diagnostic confusion (false positive test results) because of the possibility of identifying a finding that was present before symptoms began and therefore has no temporal association with the symptoms. With the lack of red flags and the lack of a significant change in injury status the request for Lumbar X-rays is not medically necessary.