

<b>Case Number:</b>	CM14-0100146		
<b>Date Assigned:</b>	07/28/2014	<b>Date of Injury:</b>	12/03/2009
<b>Decision Date:</b>	09/22/2014	<b>UR Denial Date:</b>	06/02/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	06/30/2014

### 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 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 62-year-old male, who reported an injury on 12/03/2009. The mechanism of injury was not provided. On 05/12/2014, the injured worker presented with low back pain radiating to his left lower extremity, down his left knee. Upon examination of the lumbar spine, there is tenderness noted over the lumbosacral spine and over the bilateral lumbar paraspinal musculature. The range of motion values of the lumbar spine were 45 degrees of flexion, 15 degrees of extension, and 15 degrees of lateral bending. There was increased lower back pain reported upon the extremes of all range of motion. The diagnoses were sprain/strain of the lumbar spine with bulging discs and radiculopathy, right plantar fasciitis, and left plantar fasciitis. MRI of the lumbar spine, performed on 02/11/2014, revealed L1-2 loss of nucleus pulposus and mild diffuse anterior flattening of the dura. There is also L2-3 loss of nucleus pulposus, L3-4 disc space narrowing and loss of nucleus pulposus, L4-5 loss of nucleus pulposus, and L5-S1 no evidence for disc bulge or central canal narrowing. The provider recommended continued chiropractic sessions and a functional restoration program for the lumbar spine; the provider's rationale was not provided. The Request for Authorization form was not included in the medical documents for review.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Continued Chiropractic Sessions 3X6 (Lumbar): Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Manual Therapy and Manipulation.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Page(s): 58.

**Decision rationale:** MTUS Guidelines state that chiropractic care for chronic pain caused by musculoskeletal conditions is recommended. The intended goal or effect of manual medicine is the achievement of positive symptomatic or objective measurable gains in functional improvement that facilitate progression in the patient's therapeutic exercise program and the return of productive activities. The guidelines recommend a trial of 6 visits over 2 weeks and with evidence of objective functional improvement prior to allowance of up to 18 visits over 6 to 8 weeks. There was a lack of documentation indicating the injured worker had significant objective functional improvement with the prior therapy. The amount of prior chiropractic sessions that were already completed was not provided. As such, medical necessity has not been established.

**Functional Restoration Program 3X6 (Lumbar):** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Chronic Pain Programs (Functional Restoration Programs).

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Chronic Pain Programs (Functional Restoration Programs) Page(s): 30-32.

**Decision rationale:** MTUS Guidelines state that an adequate and thorough evaluation needs to be made, including baseline functional testing, so that followup with the same tests can note functional improvement; previous methods of treating chronic pain have been unsuccessful; and, there is an absence of other options likely to result in significant clinical improvement. Injured worker must have had significant loss of ability to function independently, resulting from chronic pain; the injured worker is not a candidate where surgery or other treatments would be clinically warranted; and, the injured worker must exhibit motivation to change. Negative predictors of success should also be addressed. Functional restoration treatment is not suggested for longer than 2 weeks without evidence of demonstrated efficacy as documented by subjective and objective gains. Total treatment duration should generally not exceed 20 full day sessions, and a treatment duration in excess of 20 sessions requires a clear rationale for this specified extension and reasonable goals to be achieved. There was lack of a measurable baseline against which to measure the efficacy of the functional restoration program. Additionally, there was lack of evidence that the injured worker had failed conservative treatment, to include physical medicine and medications. There was lack of documentation of other treatments the injured worker underwent previously and the measurement of progress as well as efficacy of prior treatments. As such, the request is not medically necessary.