

<b>Case Number:</b>	CM14-0110889		
<b>Date Assigned:</b>	08/01/2014	<b>Date of Injury:</b>	06/23/2013
<b>Decision Date:</b>	12/23/2014	<b>UR Denial Date:</b>	07/01/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	07/16/2014

### 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 Interventional Spine 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 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 51-year-old male with a date of injury of 06/23/2013. The listed diagnoses are: 1. Lumbosacral disk disease. 2. Lumbar facet syndrome. 3. Myalgia. According to Doctor's First Report, 06/13/2014, the patient presents with right and center low back pain. Examination revealed "lumbar ROM, decreased flexion, extension are R&L lateral flex, all w/stiffness, R&L rotation, decreased R patellar reflex +1. Positive ortho, Kemp's, Valsalva. Pain from L4 to S1 with palpation." Physician is requesting 2 times a week for 6 weeks chiropractic therapy with myofascial release, hydrotherapy, mechanical traction, and acupuncture. Utilization Review denied the request on 07/01/2014. Treatment reports from 12/05/2013 through 06/03/2014 were reviewed.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Initial Chiropractic Therapy 2 x 6, lumbar spine:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Manual Therapy and Manipulation. Decision based on Non-MTUS Citation Official Disability Guidelines - TWC: Low Back Procedure Summary

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

**Decision rationale:** This patient presents with right and center low back pain. The physician is requesting Initial chiropractic therapy 2x6, lumbar spine. This is a Doctor's First Report and the physician has stated that this is an initial request for chiropractic care. Prior progress report by Orthopedic Surgeon Dr, notes that on 03/30/2014 recommendation was made for chiropractic and acupuncture treatments. On 05/22/2014 the patient was recommended to "continue acupuncture." It appears the patient has participated in chiropractic treatment in the past. The number of prior treatment and the results are not discussed. MTUS recommends as an option trial of 6 visits over 2 weeks, with evidence of objective functional improvement, total of up to 18 visits over 6-8 weeks. For recurrences/flare-ups re-evaluate treatment success and if RTW is achieved then 1-2 visits every 4-6 months. Physician does not indicate that return to work is achieved in this patient. There is also no documented evidence of objective functional improvement to support the medical necessity of additional visits. The Initial Chiropractic Therapy 2 x 6, lumbar spine is not medically necessary.

**Myofascial Release:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Massage Therapy.

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

**Decision rationale:** This patient presents with right and center low back pain. Physician request chiropractic therapy 2x6 and myofascial release, hydrotherapy, and mechanical traction. This is a Doctor's First Report and the physician has stated that this is an initial request for chiropractic care. Prior progress report by Orthopedic Surgeon Dr. \_\_, notes that on 03/30/2014 recommendation was made for chiropractic and acupuncture treatments. On 05/22/2014 the patient was recommended to "continue acupuncture." It appears the patient has participated in chiropractic treatment in the past. The number of prior treatment and the results are not discussed. MTUS recommends as an option trial of 6 visits over 2 weeks, with evidence of objective functional improvement, total of up to 18 visits over 6-8 weeks. For recurrences/flare-ups re-evaluate treatment success and if RTW is achieved then 1-2 visits every 4-6 months. Physician does not indicate that return to work is achieved in this patient. There is also no documented evidence of objective functional improvement to support the medical necessity of additional visits. Therefore, Myofascial Release is not medically necessary.

**Hydrotherapy:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Aquatic Therapy.

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

**Decision rationale:** This patient presents with right and center low back pain. The physician is requesting chiropractic therapy x12 sessions, myofascial release, hydrotherapy, and mechanical traction. This is a Doctor's First Report and the physician has stated that this is an initial request for chiropractic care. Prior progress report by Orthopedic Surgeon Dr. \_\_, notes that on 03/30/2014 recommendation was made for chiropractic and acupuncture treatments. On 05/22/2014 the patient was recommended to "continue acupuncture." It appears the patient has participated in chiropractic treatment in the past. The number of prior treatment and the results are not discussed. MTUS recommends as an option trial of 6 visits over 2 weeks, with evidence of objective functional improvement, total of up to 18 visits over 6-8 weeks. For recurrences/flare-ups re-evaluate treatment success and if RTW is achieved then 1-2 visits every 4-6 months. Physician does not indicate that return to work is achieved in this patient. There is also no documented evidence of objective functional improvement to support the medical necessity of additional visits. Therefore, Hydrotherapy is not medically necessary.

**Acupuncture:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Acupuncture Treatment Guidelines.

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

**Decision rationale:** This patient presents with right and center low back pain. Physician is requesting acupuncture sessions. Doctor's First Report from 06/13/2014 indicates that the request is for 2x6 sessions. For acupuncture, MTUS Guidelines page 8 recommends acupuncture for pain, suffering, and for restoration of function. Recommended frequency and duration is 3 to 6 treatments for trial and with functional improvement, 1 to 2 times per day with optimal duration of 1 to 2 months. For additional treatment, MTUS requires functional improvement as defined by Labor Code 9792.20(e) as significant improvement in ADLs, or change in work status AND reduced dependence on medical treatments. Progress report 03/30/2014 and 04/17/2014 indicates that the patient has had acupuncture treatments in the past. The number of treatments and when they were received are not documented. In this case, the physician's request for 12 additional sessions exceeds what is recommended by MTUS. Furthermore, there is no documented functional improvement to consider additional treatment. Therefore, Acupuncture is not medically necessary.

**Mechanical Traction:** 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 Manual therapy & manipulation Page(s): 58-59.

**Decision rationale:** This patient presents with right and center low back pain. The physician is requesting chiropractic therapy x12 sessions, myofascial release, hydrotherapy, and mechanical

traction. This is a Doctor's First Report and the physician has stated that this is an initial request for chiropractic care. Prior progress report by Orthopedic Surgeon Dr. \_\_, notes that on 03/30/2014 recommendation was made for chiropractic and acupuncture treatments. On 05/22/2014 the patient was recommended to "continue acupuncture." It appears the patient has participated in chiropractic treatment in the past. The number of prior treatment and the results are not discussed. MTUS recommends as an option trial of 6 visits over 2 weeks, with evidence of objective functional improvement, total of up to 18 visits over 6-8 weeks. For recurrences/flare-ups re-evaluate treatment success and if RTW is achieved then 1-2 visits every 4-6 months. Physician does not indicate that return to work is achieved in this patient. There is also no documented evidence of objective functional improvement to support the medical necessity of additional visits. Therefore, Mechanical Traction is not medically necessary.