

<b>Case Number:</b>	CM15-0103938		
<b>Date Assigned:</b>	06/08/2015	<b>Date of Injury:</b>	03/01/2012
<b>Decision Date:</b>	07/10/2015	<b>UR Denial Date:</b>	04/24/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	05/29/2015

### 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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:

State(s) of Licensure: Iowa, Illinois, Hawaii

Certification(s)/Specialty: Preventive Medicine, Occupational Medicine, Public Health & General Preventive Medicine

### 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 34-year-old male, who sustained an industrial injury on 3/1/2012. He reported low back, right knee and right ankle pain. The injured worker was diagnosed as having lumbar radiculopathy, lumbar sprain/strain, status post right knee surgery, and status post right ankle surgery. Treatment to date has included medications, ankle and knee surgery. The request is for chiropractic therapy, and range of motion testing for the lumbar spine and right leg. On 4/14/2015, he complained of pain to the low back with radiation to the legs. He rated this pain 5/10. He also complained of right knee pain rated 4/10, and right ankle pain rated 4/10. Physical findings noted decreased range of motion and tenderness to the low back, right knee and right ankle. The treatment plan included: orthopedic consultation, and CMT.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Chiropractic 1x6 for the lumbar spine:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines manual therapy & manipulation.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Manual therapy & manipulation Page(s): 58-60. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back - Lumbar & Thoracic (Acute & Chronic), Chiropractic, Manipulation.

**Decision rationale:** ODG recommends chiropractic treatment as an option for acute low back pain, but additionally clarifies that "medical evidence shows good outcomes from the use of manipulation in acute low back pain without radiculopathy (but also not necessarily any better than outcomes from other recommended treatments). If manipulation has not resulted in functional improvement in the first one or two weeks, it should be stopped and the patient reevaluated. " Additionally, MTUS states "Low back: Recommended as an option. Therapeutic care, Trial of 6 visits over 2 weeks, with evidence of objective functional improvement, total of up to 18 visits over 6-8 weeks. Elective /maintenance care not medically necessary. Recurrences/flare-ups will need to reevaluate treatment success, if RTW achieved then 1-2 visits every 4-6 months. Medical documents indicate that patient has undergone approximately 18 chiropractic sessions, which would not be considered in the "trial period" anymore. The treating provider has not demonstrated evidence of objective and measurable functional improvement during or after the trial of therapeutic care to warrant continued treatment. As such, the request for Chiropractic 1x6 for the lumbar spine is not medically necessary.

**Range of motion testing:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines Computerized Range of Motion Testing.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 2 General Approach to Initial Assessment and Documentation Page(s): 31-37, Chronic Pain Treatment Guidelines Page(s): 47. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back, Range of Motion.

**Decision rationale:** The MTUS states, "Physical Impairments (e. g. , joint ROM, muscle flexibility, strength, or endurance deficits): Include objective measures of clinical exam findings. ROM should be in documented in degrees. " In the ACOEM physical examination portion it states Muscle testing and range of motion testing (ROM) are integral parts of a physical examination. This can be done either manually, or with computers or other testing devices. It is the treating physician's prerogative to perform a physical examination with or without muscle testing and ROM devices. However, in order to bill for this sort of test as a stand-alone diagnostic procedure, there must be medical necessity above and beyond the usual requirements of a medical examination, and the results must significantly impact the treatment plan. Muscle testing and range of motion testing as stand-alone procedures would rarely be needed as part of typical injury treatment. In this case, there is no evidence that the ROM muscle tests are clinically necessary and relevant in developing a treatment plan. While the ACOEM Guidelines do not comment specifically on this issue, other than to recommend a thorough history and physical examination, for which no computerized devices are recommended for measuring ROM or muscle testing. The treating physician did not provide specific rationale for this request. As such the request for Range of motion testing is not medically necessary.