

<b>Case Number:</b>	CM15-0057827		
<b>Date Assigned:</b>	04/02/2015	<b>Date of Injury:</b>	03/23/2013
<b>Decision Date:</b>	05/08/2015	<b>UR Denial Date:</b>	03/09/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	03/26/2015

### 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 31 year old male, who sustained an industrial injury on March 23, 2013. The injured worker reported back pain. The injured worker was diagnosed as having low back pain and unspecified lumbar disc disorder. Treatment and diagnostic studies to date have included magnetic resonance imaging (MRI), physical therapy and medication. A panel qualified medical report dated February 11, 2015 provides the injured worker complains of back pain, testicular and right knee pain. Physical exam notes left thigh atrophy. Recommendation is for psychiatric evaluation, physical therapy, medication and electromyogram and nerve conduction study.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**12 Chiropractic Sessions:** Upheld

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

**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. Need to reevaluate treatment success, if RTW achieved then 1-2 visits every 4-6 months." Medical documents do not indicate if this patient has undergone previous chiropractic sessions, the requested number of sessions would be in excess of guideline trial recommendations. As such, the request for 12 Chiropractic Sessions is not medically necessary.

## **12 Physical Therapy Sessions for The Lumbar Spine: Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 287-315, Chronic Pain Treatment Guidelines Physical Therapy, Physical Medicine Page(s): 98-99. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back - Lumbar & Thoracic (Acute & Chronic), Physical Therapy.

**Decision rationale:** California MTUS guidelines refer to physical medicine guidelines for physical therapy and recommends as follows: "Allow for fading of treatment frequency (from up to 3 visits per week to 1 or less), plus active self-directed home Physical Medicine." Additionally, ACOEM guidelines advise against passive modalities by a therapist unless exercises are to be carried out at home by patient. ODG quantifies its recommendations with 10 visits over 8 weeks for lumbar sprains/strains and 9 visits over 8 weeks for unspecified backache/lumbago. ODG further states that a "six-visit clinical trial" of physical therapy with documented objective and subjective improvements should occur initially before additional sessions are to be warranted. It is unclear by the medical records provided if this patient has undergone physical therapy during recent treatment period. Guidelines do allow for physical therapy for exacerbation of back pain, however the requested number of guidelines recommend 10 visits for sprain/strain or 9 visits for unspecified backache/lumbago. The requested number of treatments is in excess of guideline recommendations. As such, the request for 12 Physical Therapy Sessions for The Lumbar Spine is not medically necessary.