

Case Number:	CM13-0018535		
Date Assigned:	10/11/2013	Date of Injury:	06/04/2013
Decision Date:	08/26/2014	UR Denial Date:	08/20/2013
Priority:	Standard	Application Received:	08/29/2013

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 Occupational Medicine 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 31 year old female who sustained an injury on 6/4/13. The patient reports that on the date of the injury she injured her right knee and low back while moving a mattress. The patient is diagnosed with thoracic or lumbo sacral radiculitis, internal derangement of knee, disorder of bursa and tendons in the shoulder region, and displacement of lumbar intervertebral disc without myelopathy. UR 8/20/13 recommended to non-certify 6 chiropractic adjustments with trigger point injections, electrical muscle stimulation, heat, ice, vibratory massage and functional restoration. The 7/31/13 exam was reviewed and it was noted that treatment to date has consisted of 12 chiropractic sessions. The exam also noted that progress is slower than expected. The peer reviewer noted that the guidelines support additional chiropractic care after initial trial of 6 visits demonstrated objective functional improvement. It was noted that the current progress report noted the patient is progressing at slower rate than expected and continues to have pain with positive orthopedic test and limited range of motion. The peer review noted that the guidelines do not offer strong support for the use of massage, Tens, hot or cold therapies. The peer reviewer also noted that the guidelines were not met for trigger point injections and functional rehabilitation program. May 7, 2014 examination notes that the patient has had 18 sessions of chiropractic treatment with temporary benefit. The report also notes that the patient is not a surgical candidate. The surgeon had recommend a need for physical therapy strengthening and work hardening program. The medical records indicate that treatment has also consisted of medications and lumbar epidural steroid injections.

IMR ISSUES, DECISIONS AND RATIONALES

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

6 CHIRO ADJUSTMENTS - WITH TRIGGER POINT INJECTIONS: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Manual therapy & manipulation, Trigger point injections Page(s): 58-59, 121-122.

Decision rationale: The request for 6 chiropractic adjustment with trigger point injections is not necessary. The medical records indicate that the patient has undergone chiropractic treatments without benefit. In the absence of objective functional benefit, the request for additional chiropractic care is not supported. In addition, the patient does not meet the criteria for trigger point injections. The patient has been given a diagnoses of radiculopathy, and per the guidelines which per the guidelines would not support trigger point injections. Further, there is no documentation of circumscribed trigger points with evidence upon palpation of a twitch response as well as referred pain. As such, the request for chiropractic adjustment with trigger point injections is not medically necessary.

ELECTRIC MUSCLE STIMULATION: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Transcutaneous electrotherapy Page(s): 112-114.

Decision rationale: The request for electrical stimulation is not supported. The guidelines indicate that Tens unit may be used for neuropathic pain (including diabetic neuropathy) and post-herpetic neuralgia, Phantom limb pain and CRPS II, spasticity in spinal cord injury, and Multiple sclerosis (MS). The patient is not diagnosed with conditions which would support electrical stimulation.

HEAT AND COLD THERAPY: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back Chapter, Heat therapy, Cold therapy.

Decision rationale: The request for Cold/Hot therapy is noted to be an adjunct for manipulations. As noted above, the request for manipulation has not been certified. Furthermore, while home placement of cold and hot packs is supported, the medical necessity of formal office treatment with these modalities is not supported and deemed medically necessary.

VIBRATORY MASSAGE: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Massage therapy Page(s): 59-60.

Decision rationale: References state that massage should be an adjunct to other recommended treatment (e.g. exercise), and it should be limited to 4-6 visits in most cases. In this case, this request is noted to be adjunct to manipulation which has not been determined to be medically necessary. Furthermore, there is no evidence that prior treatment with massage has provided objective functional improvement. As such, this request is not medically necessary.

FUNCTIONAL RESTORATION: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Functional Restoration Program Page(s): 30-34.

Decision rationale: The request for functional restoration program is not supported. The medical records do not establish that the patient has exhausted conservative care options. Furthermore, there is no evidence that an evaluation has been performed for this program/treatment to support entering the requested program. The request for functional restoration is not medically necessary.