

<b>Case Number:</b>	CM13-0023092		
<b>Date Assigned:</b>	03/03/2014	<b>Date of Injury:</b>	04/01/1980
<b>Decision Date:</b>	05/21/2014	<b>UR Denial Date:</b>	08/27/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	09/11/2013

### 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 an employee of [REDACTED] and has submitted a claim for lumbar disk displacement associated with an industrial injury date of April 1, 1980. Utilization review from August 27, 2013 denied the requests for chiropractic treatments due to no documentation of functional loss, electrical muscle stimulator due to no documentation of functional loss, and myofascial release therapy due to no documentation of functional loss. Treatment to date has included heat/ice therapy and opioid and non-opioid pain medications. Medical records from 2012 through 2013 were reviewed showing a recent flareup of the patient's pain. The patient complains of back pain which is rated at 8/10. This is aggravated by movement particularly extension of his back. Physical exam demonstrated decreased lumbar range of motion with moderate spasms of the back muscles.

### IMR ISSUES, DECISIONS AND RATIONALES

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

#### **CHIROPRACTIC TREATMENTS, QTY 4: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 58.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 58-60.

**Decision rationale:** As stated on pages 58-60 of the CA MTUS Chronic Pain Medical Treatment Guidelines, manipulation is recommended for chronic pain is caused by musculoskeletal conditions. In this case, the patient was reported to have a flare up of his back pain. However, given the date of injury, it is unclear whether the patient has had prior chiropractic treatments in the past; outcomes from the sessions were not documented. The request does not indicate a body part being treated. Therefore, the request for chiropractic treatments is not medically necessary.

**ELECTRIC MUSCLE STIMULATOR, QTY 4:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 121.

**Decision rationale:** As stated on page 121 of the California MTUS Chronic Pain Medical Treatment Guidelines, neuromuscular electrical stimulation is not recommended and it is primarily used as part of a rehabilitation program following stroke and there is no evidence to support its use in chronic pain. In this case, the patient is suffering from chronic pain since 1980. There is no discussion concerning the need for variance from the guidelines. Therefore, the request for electric muscle stimulator is not medically necessary.

**MYOFASCIAL RELEASE THERAPY:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 48.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 60.

**Decision rationale:** As stated on page 60 of the California MTUS Chronic Pain Medical Treatment Guidelines, massage therapy is recommended as an option and as an adjunct to other recommended treatment such as exercise, and should be limited to no more than 4-6 visits. In this case, it is unclear whether the patient has had prior myofascial release therapy given an injury date of 1980. The treatment history is relatively unclear. Outcomes concerning previous treatment were not clearly documented. The request does not indicate a specific body part to be treated. Therefore, the request for myofascial release therapy is not medically necessary.