MAXIMUS Federal Services

Case Number:	CM13-0055537		
Date Assigned:	12/30/2013	Date of Injury:	08/23/2013
Decision Date:	03/24/2014	UR Denial Date:	11/08/2013
Priority:	Standard	Application Received:	11/21/2013

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Physical Medicine and Rheabilitation, 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 physician 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 37 year old female who sustained an injury on 08/23/2013 while slipping on water and falling on the hard floor injuring her neck, back, left shoulder, left hip and left leg. The patient has been treated with prescription medication (Flexeril and Vicodin), physical therapy, home exercises, work restrictions, and 3 sessions of chiropractic treatment (10/31/2013, 12/05/2013, and 01/12/2014). On 10/07/2013 the patient had an MRI of the lumbar spine which revealed desiccation, 3mm posterior central and left paracentral disc protrusion, L5-S1 with degenerative facet changes. A clinic note dated 09/19/2013 indicates the patient had some tenderness in the thoracic area from D8-D12, left greater than right and paraspinal muscle spasm plus, guarding plus. The patient had significant limited range of motion of the lumbar spine which the patient was not asked to perform the flexion and extension because of severity of pain. The patient had significant limitation and pain on range of motion to the lumbar spine, spasms plus. There was guarding plus from T12 to S1, bilaterally, especially in the left lower extremity. The patient had tenderness over L4-5, L5-S1 and the paradorsal muscles, but especially over L4-5 and L5-S1. The patient had a straight leg raising test, bilaterally which produced pain in the lower back, especially on the left lower extremity and she raised it approximately 40 degrees. The patient had significant pain in the lower back and had no sensory deficits in the lower extremities. Motor power was seen to be intact in both lower extremities except on the left fifth toe. The patient seemed to have slightly decreased pain. Reflexes were intact, bilaterally. Diagnoses include dorsal lumbosacral strain and sprain (9847.2); rule out herniated nucleus pulposus L4-5, L5-S1 with L5 radiculopathy (722.10.724.4); upper trapezius cervical strain and sprain (847.0) and thoracic strain and sprain (847.1). The current review is for chiropractic treatment for the cervical and lumbar, 3x6 and IF unit for home use.

IMR ISSUES, DECISIONS AND RATIONALES

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

Chiro cervical and lumbar 3x6: 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 Section on Manual therapy & manipulation Page(s): 58-60.

Decision rationale: As per the MTUS Chronic Pain Guidelines, chiropractic treatment is recommended for chronic pain with the intended goal to achieve positive symptomatic or objective measurable gains in functional improvement that facilitate progression in the patient's therapeutic exercise program and return to productive activities. Guidelines further recommend "an initial trial of 6-12 visits over a 2-4 week period, and, at the midway point as well as at the end of the trial there should be a formal assessment whether the treatment is continuing to produce satisfactory clinical gains. If the criteria to support continuing chiropractic care (substantive, measurable functional gains with remaining functional deficits) have been achieved, a follow up course of treatment may be indicated consisting of another 4-12 visits over a 2-4 week period." The frequency allowed per guidelines is 1 to 2 times per week the first 2 weeks and 1 treatment per week for the next 6 weeks. The provider has requested 3x6 (18) chiropractic care for cervical and lumbar spine, which exceeds the MTUS Chronic Pain Guidelines' recommended frequency. Also, there is no mention about follow up evaluation to determine objective functional improvement. Thus, the request is not medically necessary and appropriate.

IF Unit for home use: Overturned

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 Section on Interferential Current Stimulation Page(s): 118-120.

Decision rationale: As per the MTUS Chronic Pain Guidelines, interferential stimulator use is "not recommended as an isolated intervention. There is no quality evidence of effectiveness except in conjunction with recommended treatments, including return to work, exercise and medications, and limited evidence of improvement on those recommended treatments alone." This patient continues to have subjective, objective and functional limitations. She has been unresponsive to the conservative measures such as physical therapy, home exercises, and medications. Thus, the criteria for one-month trial are appropriate to monitor the effects and benefits from its use. The request for an IF unit for home use is medically necessary and appropriate.