

Case Number:	CM14-0018271		
Date Assigned:	04/21/2014	Date of Injury:	06/06/2013
Decision Date:	07/02/2014	UR Denial Date:	02/03/2014
Priority:	Standard	Application Received:	02/13/2014

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 Anesthesiology, has a subspecialty in Pain Medicine and is licensed to practice in Florida. 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 injured worker is a 48 year old male who reported an injury on 08/06/2013 secondary to lifting. The diagnoses are bilateral shoulder sprain/strain, lumbar spine sprain/strain with bilateral lower extremity radiculopathy and annular tears of L4-L5, L5-S1. The injured worker was evaluated on 11/21/2013 for reports of low back pain with radiating pain, numbness and tingling to the bilateral lower extremities and bilateral shoulder pain. The exam noted tenderness, spasm and guarding at the lumbar spine with positive straight leg raise bilaterally. The lumbar range of motion was flexion at 8 degrees, extension at 3 degrees, right sided bending at 7 degrees and left sided bending at 5 degrees. The treatment plan indicated chiropractic services, Orthostim4 for home use, MRI of the lumbar spine and EMG/NCV studies of the bilateral lower extremities. The official MRI of the lumbar spine was completed on 12/11/2013 and noted L4-L5 disc protrusion with abutment of the right L5 nerve root and mild canal narrowing, L5-S1 disc protrusion with mild effacement of the anterior thecal sac with no neural abutment and posterior annular tear at L4-L5 and L5-S1. There is a request for authorization in the documentation; however, there is no indication of rationale.

IMR ISSUES, DECISIONS AND RATIONALES

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

8 CHIROPRACTIC VISITS WITH EXERCISE REHABILITATION AND MODALITIES, 2 TIMES 4: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines MANUAL THERAPY AND MANIPULATION.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines MANUAL THERAPY AND MANIPULATION Page(s): 58-59.

Decision rationale: The California Medical Treatment Utilization Schedule (MTUS) Chronic Pain Medical Treatment Guidelines Manual Therapy and Manipulation recommend manual therapy for chronic pain caused by musculoskeletal conditions to achieve measurable improvement in function and activities. The guidelines recommend a trial of 6 visits over 2 weeks with evidence of objective functional improvement. The request is for 8 visits which exceed the total number for the trial period. Therefore, based on the information provided, the request is not medically necessary and appropriate.

ORTHSTIM4 HOME ELECTRICAL MUSCLE STIMULATION UNIT: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines TENS, CHRONIC PAIN, TRANSCUTANEOUS ELECTRICAL NERVE STIMULATION.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines TRANSCUTANEOUS ELECTROTHERAPY Page(s): 114-116.

Decision rationale: The request for Orthstim4 unit purchase is non-certified. The Orthstim4 includes high volt pulsed current stimulation, neuromuscular electrical stimulation; interferential stimulation pulsed and direct current stimulation. The California Medical Treatment Utilization Schedule (MTUS) Chronic Pain Medical Treatment Guidelines state that TENS is not recommended as a primary treatment modality, but a one-month home-based TENS trial may be considered as a noninvasive conservative option. There must be documentation of 3 months duration of pain, other appropriate modalities have been tried and failed, the one-month trial should be documented with how often the unit was used as well as the outcome of the use, presence of a treatment plan with short and long-term goals of the TENS treatment. There is documentation of three months duration of pain and use of pain medications; however, there is no evidence of the frequency of use and efficacy during the trial period or a TENS treatment plan. Based on the documentation provided, the request is not medically necessary and appropriate.

EMG/NCV OF THE BILATERAL LOWER EXTREMITIES: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 303-305.

Decision rationale: The request for Electromyography (EMG)/ Nerve Conduction Velocity (NCV) of bilateral lower extremities is non-certified. The California MTUS/ACOEM guidelines

state EMG studies can help identify subtle dysfunction in patients with low back symptoms lasting more than three to four weeks when there is an emergence of a red flag, evidence of tissue insult or dysfunction, failure to progress in a strengthening program. The injured worker has had reports of low back pain; however, there is no evidence noted of conservative treatment measures such as physical therapy or any red flags. In addition, there is a lack of evidence of peripheral neuropathy to warrant the need for an NCV study. Based on the documentation provided, the request is not medically necessary and appropriate.