MAXIMUS Federal Services

Case Number:	CM14-0110652		
Date Assigned:	08/01/2014	Date of Injury:	04/21/2014
Decision Date:	09/09/2014	UR Denial Date:	07/03/2014
Priority:	Standard	Application Received:	07/15/2014

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 licensed in Chiropractic Services and is licensed to practice in Texas. 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 49-year-old male who reported an injury on 04/21/2014. The mechanism of injury was noted to be a twisting step taken on a stair. His diagnoses were noted to be strain: lumbosacral, right greater than left; pain: low back; and weakness: right lower extremity. Prior treatment was noted to be physical therapy, chiropractic therapy, home exercise program, and medications. The injured worker had an MRI of the lumbar spine without contrast. The injured worker had subjective complaints of low back pain and weakness. It was noted the right side was greater than the left. The objective physical exam findings indicated tenderness to palpation of the lumbar spine, discomfort with range of motion, straight leg raise was positive with moderate pain, and lower extremity motor exam findings were 5/5 bilaterally. Medications were noted to be Naprosyn, Vicoprofen, and Xanax. The treatment plan was for physical therapy and medications. The provider's rationale for the request was within the documentation submitted for review. A Request for Authorization was included within the review and dated 06/20/2014.

IMR ISSUES, DECISIONS AND RATIONALES

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

Chiropractic therapy, three sessions per week for four weeks to the lumbar spine: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Page(s): 298. Decision based on Non-MTUS Citation Official Disability Guidelines, low back - lumbar and thoracic (acute and chronic) and chiropractic guidelines: therpeutic care sections.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Manual therapy & manipulation Page(s): 58-60.

Decision rationale: The California MTUS Chronic Pain Medical Treatment Guidelines recommend manual therapy and manipulation for chronic pain if caused by musculoskeletal conditions. Manual therapy is widely used in the treatment of musculoskeletal pain. The intended goal or effect of manual medicine is the achievement of positive symptomatic or objective measurable gains in functional improvement that facilitate progression in the patient's therapeutic exercise program and return to activities. Therapeutic care of the low back provides a trial of 6 visits over 2 weeks and with evidence of objective functional improvement; a total of up to 18 visits over 6 to 8 weeks. For elective or maintenance care, the guidelines state no medical need. For recurrences and flare ups; a need to re-evaluate treatment success and a return to work must be documented; then 1 to 2 visits are recommended every 4 to 6 months. The injured worker had prior chiropractic therapy. It is not noted in the clinical evaluation if that was an effective therapeutic treatment. It is not noted that the injured worker has a return to work plan. According to the guidelines, the criteria have not been met for additional therapy. In addition, the provider's request is in excess of the guidelines' number of visits recommended. Therefore, the request for Chiropractic therapy, three sessions per week for four weeks to the lumbar spine is not medically necessary and appropriate.

Home electrical muscle stimulation unit purchase: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Page(s): 300.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Neuromuscular electrical stimulation (NMES devices) Page(s): 121.

Decision rationale: The California MTUS Chronic Pain Medical Treatment Guidelines do not recommend neuromuscular electrical stimulation. It is used primarily as part of a rehabilitation program following stroke, and there is no evidence to support its use in chronic pain. As such, the request for home electrical muscle stimulation unit purchase is not medically necessary and appropriate.