

Case Number:	CM14-0174934		
Date Assigned:	10/28/2014	Date of Injury:	08/07/2014
Decision Date:	12/24/2014	UR Denial Date:	10/14/2014
Priority:	Standard	Application Received:	10/22/2014

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 Internal 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 claimant is a 66 year old female who sustained an industrial injury on 08/07/2014. The mechanism of injury was not submitted with the review. Her diagnoses include low back pain, left groin pain, intermittent numbness and tingling in the left leg into the left foot, left shoulder and left hip pain. She continues to complain of low back pain. On physical exam there is pain with lumbar range of motion with flexion at 45 degrees. Motor and sensory exams are normal. Treatment has included medical therapy and physical therapy. The treating provider has requested Chiropractic services, 2 x 4 for the low back, left hip and thigh and Laser therapy, 2 x 3 for the low back, left hip and thigh.

IMR ISSUES, DECISIONS AND RATIONALES

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

Chiropractic services, 2 times a week for 4 weeks for the low back, left hip and thigh:
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 Page(s): 58.

Decision rationale: Chiropractic therapy is recommended 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 productive activities. Manipulation is manual therapy that moves a joint beyond the physiologic range-of-motion but not beyond the anatomic range-of-motion. Low back: Recommended as an option. Therapeutic care - Trial of 6 visits over 2 weeks, with evidence of objective functional improvement, total of up to 18 visits over 6-8 weeks. Elective/maintenance care - Not medically necessary. Recurrences/flare-ups - Need to reevaluate treatment success, if RTW (return to work) achieved then 1-2 visits every 4-6 months. The documentation indicates that there was no reported improvement with physical therapy. There is also no documentation as to why the claimant is not able to continue with rehabilitation with a home exercise program. Medical necessity for the requested item is not established. The requested item is not medically necessary.

Laser therapy, 2 times a week for 3 weeks for the low back, left hip and thigh: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Level Laser Therapy

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain

Decision rationale: Per the ODG Guidelines, cold laser therapy (also known as low-level laser therapy or class III laser) and high-power laser therapy (class IV therapeutic laser) are considered experimental and investigational because there is inadequate evidence of the effectiveness of cold laser therapy and high-power laser therapy in pain relief (e.g. acute and chronic low back pain/neck pain, orthodontic pain, shoulder pain), wound healing, or for other indications such as carpal tunnel syndrome, colorectal cancer, dentin hypersensitivity, elbow disorders, fibromyalgia, herpes labialis, lymphedema, musculoskeletal dysfunction, myofascial pain syndrome, neurological dysfunctions, patella-femoral pain syndrome, physical therapy (including rehabilitation following carpal tunnel release), rheumatoid arthritis, shoulder impingement syndrome, and tinnitus. Medical necessity for the requested treatment has not been established. The requested treatment is not medically necessary.