

Case Number:	CM14-0037849		
Date Assigned:	07/28/2014	Date of Injury:	04/04/2013
Decision Date:	10/29/2014	UR Denial Date:	03/06/2014
Priority:	Standard	Application Received:	03/31/2014

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 Physical Medicine and Rehabilitation, has a subspecialty in Pain Medicine and Spinal Cord Medicine and is licensed to practice in Massachusetts. 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 has a history of a work injury occurring on 04/04/13 when, while working as a security officer and participating in training exercises, he sustained a back injury. Treatments included 16 sessions of physical therapy/chiropractic care. Chiropractic treatments are documented with six treatments completed as of 05/09/13. Treatments included electrical stimulation, heat, myofascial release, biofeedback, and manipulation. An MRI of the lumbar spine on 08/15/13 showed findings of an L5-S1 left lateralized disc protrusion with facet arthritis. He was seen on 08/29/13 for an orthopedic evaluation. His history of injury and treatments were reviewed. He was having back pain without leg symptoms. Physical examination findings included normal posture and gait. He had diffuse lumbar spine tenderness with negative straight leg raising and a normal neurological examination. He was diagnosed with a lumbar strain/sprain. Additional testing was ordered. EMG/NCV (Electromyography / Nerve Conduction Velocity) testing on 02/18/14 was negative. He was seen by the requesting provider on 01/16/14. He was having constant low back and mid back pain rated at 6-8/10. Physical examination findings included thoracic and lumbar paraspinal muscle tenderness with guarding with decreased lumbar spine range of motion. There was back pain with straight leg raising. He had normal gait. The assessment references the claimant as having previously benefited from chiropractic treatment prior to his injury, but as unhappy with the treatments provided after his injury. The claimant had noted improvement in symptoms with an electrical muscle stimulation unit. Authorization for chiropractic care two times per week for four weeks was requested. He was seen for an orthopedic evaluation on 05/15/14. He was having frequent mid and low back pain radiating to the right hip. He was not taking any medications and was working without restrictions. Physical examination findings included lumbar spine tenderness with decreased and

guarded range of motion. There was lower extremity weakness. On 08/07/14 he was reevaluated. He was referred for additional physical therapy and chiropractic care. Additional testing was ordered.

IMR ISSUES, DECISIONS AND RATIONALES

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

Interferential Stimulator 4 for 2 month rental: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Interferential current stimulation, TENS.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Interferential Current Stimulation (ICS) Page(s): 118-120.

Decision rationale: The claimant is more than 1 years status post work-related injury and continues to be treated for chronic mid and low back pain. Treatments have included physical therapy and chiropractic care. There is reference to improvement with use of a muscle stimulator. In terms of interferential current stimulation, criteria for continued use should be based on evidence of increased functional improvement, less reported pain and evidence of medication reduction. In this case, there is no evidence that these criteria have been met and therefore the requested 2 month rental was not medically necessary.

Electrodes packs #8: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: The Expert Reviewer did not cite any medical evidence for its decision.

Decision rationale: Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

Power Pack #24: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: The Expert Reviewer did not cite any medical evidence for its decision.

Decision rationale: Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

Adhesive remover towel Mint #32: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: The Expert Reviewer did not cite any medical evidence for its decision.

Decision rationale: Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

Shipping and Handling: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: The Expert Reviewer did not cite any medical evidence for its decision.

Decision rationale: Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

TT & SS Leadwire: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: The Expert Reviewer did not cite any medical evidence for its decision.

Decision rationale: Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

Eight (8) Chiropractic Manipulation therapy sessions to lumbar spine: 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 & manipulation Page(s): 58-59.

Decision rationale: The claimant is more than 1 years status post work-related injury and continues to be treated for chronic mid and low back pain. Treatments have included physical therapy and chiropractic care. There is reference to improvement with use of a muscle stimulator. Chiropractic treatment is recommended for chronic pain if caused by musculoskeletal conditions with a trial of 6 visits with treatment beyond 4-6 visits with documented objective improvement in function. In this case, the claimant has already undergone a course of chiropractic treatments. Additionally, the number of treatments being requested is in excess of recommended guidelines. Therefore, the requested eight (8) Chiropractic Manipulation therapy sessions to lumbar spine are not medically necessary and appropriate.