

Case Number:	CM14-0062639		
Date Assigned:	07/11/2014	Date of Injury:	07/23/2007
Decision Date:	08/14/2014	UR Denial Date:	04/17/2014
Priority:	Standard	Application Received:	05/05/2014

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 Chiropractor 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 63-year-old female who reported an injury on 07/23/2007 after being shoved by someone that was running. The injured worker had a history of neck pain and lower back pain. The injured worker had diagnoses of brachial neuritis, strain lumbar region, and disc. The injured worker had an MRI performed of unknown date which revealed a disc bulge at the L4-5 and S1. The medications included Ambien, Wellbutrin, naproxen, and hydrocodone. No VAS scale was given. Per the clinical note dated 03/31/2014, the objective findings dated 03/31/2014 to the cervical region revealed active range of motion flexion 60/60 degrees, extension 40/60 degrees, right lateral flexion 25/45 degrees and left lateral flexion of 40/45 degrees, right rotation 70/80 degrees, left rotation 60/80 degrees. The objective findings of the lumbar region revealed active range of motion with a flexion of 60/90 degrees, extension 20/30 degrees, lateral flexion 20/30 degrees, and bilateral right rotation at 25/30 degrees. Deep tendon reflexes were 2/4 throughout the upper and lower extremities with normal sensation, straight leg raise was active and passive to 90 degrees without radicular symptoms. Palpatory evaluation at the L4-5 area revealed tenderness to palpation. Past treatment included physical therapy, and chiropractic therapy. The request for authorization dated 06/11/2014 was submitted with documentation. No rationale was given for the request for chiropractic treatment, K-laser treatment, ultrasound, and electrical muscle stimulation.

IMR ISSUES, DECISIONS AND RATIONALES

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

Chiropractic treatments, quantity: 12: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints, Chronic Pain Treatment Guidelines Manual therapy and manipulation Page(s): 58-60.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Manual Therapy and Manipulation Page(s): 58.

Decision rationale: The California MTUS Guidelines recommend chiropractic therapy for chronic pain that is caused by musculoskeletal condition. The intended goal or affect of manual medicine is the achievement of positive symptomatic and objective measurable gains in functional improvement that facilitate progression in the injured worker's therapeutic exercise program and return to productive activities. Therapeutic care for the lower back is recommended as an option with a trial of 6 visits over 2 weeks with evidence of objective functional improvement, a total of up to 18 visits over 6 to 8 weeks. Elective and maintenance care, there is no medical necessity for that. The documentation provided was not evident of the patient's pain level. Per the clinical notes, the objective findings are mild to moderate loss of the spinal range of motion and a positive cervical signs. The documentation also indicated that the injured worker had been receiving physical therapy. Chiropractic treatments were dated 03/31/2014 and 04/10/2014 with good releasing and some relief from the chiropractic treatments. There are no special circumstances warranted for additional therapy. As such, the request for chiropractic therapy is not medically necessary.

Electrical Muscle Stimulation (EMS), quantity: 12: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Neck & Upper Back (Acute & Chronic).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Transcutaneous electrical nerve stimulation Page(s): 116.

Decision rationale: The request for an Electrical muscle Stimulation Unit for thirty day trial for home use is non-certified. Per the Chronic Pain Medical Treatment Guidelines (MTUS) states that the Electrical Muscle Stimulation Unit is not recommended for chronic pain. It states that the Electrical Muscle Stimulation Unit should not be used as a primary treatment modality, but a one month home based Electrical Muscle Stimulation trial may be considered as a noninvasive conservative option, if used as (an adjunct to ongoing treatment modalities within functional restoration approach) with documentation of how often the unit was used, as well as outcomes in terms of pain relief and function; rental would be preferred over purchase during this trial. There was documented evidence the injured worker complained on 03/31/2014 of low back pain, there was no mention of any clinical trial the Electrical Muscle Stimulation Unit resulting on the functional improvements establishing efficacy of this device for the injured worker. In addition, the request does not specify location where the Electrical Muscle Stimulation Unit for thirty day trial for home use will be used on the injured worker. Given the above request is non-certified.. As such, the request for the electrical muscle stimulation is not medically necessary.

Ultrasound, quantity: 8: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Neck & Upper Back (Acute & Chronic).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Ultrasound, therapeutic Page(s): 123.

Decision rationale: The California MTUS Guidelines do not recommended therapeutic ultrasound is one of the most widely and frequently used electrophysical agents. Despite over 60 years of clinical use, the effectiveness of ultrasound for treating people with pain, musculoskeletal injuries, and soft tissue lesions remains questionable. There is little evidence that active therapeutic ultrasound is more effective than placebo ultrasound for treating people with pain or a range of musculoskeletal injuries or for promoting soft tissue healing. As such, the request for the ultrasound is not medically necessary.

K-Laser therapy, quantity: 8: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Pain (Chronic).

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back - Lumbar & Thoracic (Acute & Chronic).

Decision rationale: The Official Disability Guidelines do not recommend lower level laser therapy. Per the Official Disability Guidelines, given the equivocal or negative outcomes from a significant number of randomized clinical trials, it must be concluded that the body of evidence does not allow conclusions other than that of the treatment of most pain syndromes with lower level laser therapy provides at best the equivalent of a placebo effect. The request did not address the location for the K-laser therapy. As such, the request for K-Laser therapy, quantity: 8 is not medically necessary and appropriate.