

Case Number:	CM15-0108633		
Date Assigned:	06/15/2015	Date of Injury:	11/21/2014
Decision Date:	08/19/2015	UR Denial Date:	05/11/2015
Priority:	Standard	Application Received:	06/04/2015

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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:

State(s) of Licensure: Iowa, Illinois, Hawaii

Certification(s)/Specialty: Preventive Medicine, Occupational Medicine, Public Health & General Preventive Medicine

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 46 year old male, who sustained an industrial injury on 11/21/2014. He reported injury to the low back from lifting activities. Diagnoses include lumbar strain/sprain, lumbar disc displacement without myelopathy, and hypokinesia. Treatments to date include activity modification, anti-inflammatory, and physical therapy. Currently, he complained of low back pain and stiffness with radiation to bilateral legs and numbness in bilateral calf muscles. On 3/2/15, the physical examination documented decreased lumbar range of motion and decreased sensation. The straight leg raise test, Patrick Fabere tests, Yeoman's sign and sacral compression tests were all positive bilaterally. The plan of care included twelve chiropractic therapy sessions, twelve sessions for myofascial release, twelve sessions for electrical stimulation, and seven sessions of extracorporeal shockwave therapy.

IMR ISSUES, DECISIONS AND RATIONALES

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

Chiropractic therapy x12 for the lumbar spine: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Manual therapy & manipulation.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Manual therapy & manipulation Page(s): 58-60. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back - Lumbar & Thoracic (Acute & Chronic), Chiropractic, Manipulation.

Decision rationale: ODG recommends chiropractic treatment as an option for acute low back pain, but additionally clarifies that "medical evidence shows good outcomes from the use of manipulation in acute low back pain without radiculopathy (but also not necessarily any better than outcomes from other recommended treatments). If manipulation has not resulted in functional improvement in the first one or two weeks, it should be stopped and the patient reevaluated." Additionally, MTUS states "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 achieved then 1-2 visits every 4-6 months. Medical documents provided indicate that an MRI completed on 05/06/2015 diagnosed this patient with chronic compression fracture at L2, this would be a contraindication to chiropractic manipulation. As such, the request for Chiropractic therapy x12 for the lumbar spine is not medically necessary.

Myofascial release x12 sessions for the lumbar spine: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Massage Therapy Page(s): 60. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain (Chronic), Massage Therapy, Manual Therapy.

Decision rationale: MTUS states regarding massage therapy, "Recommended as an option as indicated below. This treatment should be an adjunct to other recommended treatment (e.g. exercise), and it should be limited to 4-6 visits in most cases." ODG offers additional frequency and timeline for massage therapy by recommending: a. Time to produce effect: 4 to 6 treatments. b. Frequency: 1 to 2 times per week for the first 2 weeks as indicated by the severity of the condition. Treatment may continue at 1 treatment per week for the next 6 weeks. c. Maximum duration: 8 weeks. At week 8, patients should be reevaluated. Care beyond 8 weeks may be indicated for certain chronic pain patients in whom manipulation is helpful in improving function, decreasing pain and improving quality of life. The request is in excess of the guidelines recommendation of 4-6 visits over no more than 8 week. Medical documents do not indicate reasons for treatment in excess of the 8-week maximum without. As such, the request for Myofascial release x 12 sessions for the lumbar spine is not medically necessary at this time.

Electrical stimulation x 12 sessions for the lumbar spine: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 300.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Interferential Current Stimulation, Transcutaneous electrotherapy Page(s): 54, 114-116, 118-120. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain, TENS chronic pain (transcutaneous electrical nerve stimulation).

Decision rationale: MTUS states regarding TENS unit, "not recommended as a primary treatment modality, but a one-month home-based TENS trial may be considered as a noninvasive conservative option, if used as an adjunct to a program of evidence-based functional restoration, for the conditions described below." For pain, MTUS and ODG recommend TENS (with caveats) for neuropathic pain, phantom limb pain and CRPSII, spasticity, and multiple sclerosis. The medical records do not indicate any of the previous conditions. ODG further outlines recommendations for specific body parts: Low back: Not recommended as an isolated intervention. Knee: Recommended as an option for osteoarthritis as adjunct treatment to a therapeutic exercise program. Neck: Not recommended as a primary treatment modality for use in whiplash-associated disorders, acute mechanical neck disease or chronic neck disorders with radicular findings. Ankle and foot: Not recommended. Elbow: Not recommended. Forearm, Wrist and Hand: Not recommended. Shoulder: Recommended for post-stroke rehabilitation. Medical records do not indicate conditions of the low back, knee, neck, ankle, elbow, or shoulders that meet guidelines. Of note, medical records do not indicate knee osteoarthritis. ODG further details criteria for the use of TENS for Chronic intractable pain (for the conditions noted above): (1) Documentation of pain of at least three months duration. (2) There is evidence that other appropriate pain modalities have been tried (including medication) and failed. (3) A one-month trial period of the TENS unit should be documented (as an adjunct to ongoing treatment modalities within a 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. (4) Other ongoing pain treatment should also be documented during the trial period including medication usage. (5) A treatment plan including the specific short- and long-term goals of treatment with the TENS unit should be submitted. (6) After a successful 1-month trial, continued TENS treatment may be recommended if the physician documents that the patient is likely to derive significant therapeutic benefit from continuous use of the unit over a long period of time. At this point purchase would be preferred over rental. (7) Use for acute pain (less than three months duration) other than post-operative pain is not recommended. (8) A 2-lead unit is generally recommended; if a 4-lead unit is recommended, there must be documentation of why this is necessary. The medical records do not satisfy the several criteria for selection specifically, lack of documented 1-month trial, lack of documented short-long term treatment goals with TENS unit, and unit use for acute (less than three months) pain. As such, the request for Electrical stimulation x 12 sessions for the lumbar spine is not medically necessary.

Extracorporeal Shockwave Therapy x 7 treatments for the lumbar spine: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines Lumbar Chapter Shock wave therapy.

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), Shock wave therapy.

Decision rationale: MTUS does not specifically refer to Electric Shockwave therapy. ODG states "not recommended. The available evidence does not support the effectiveness of ultrasound or shock wave for treating LBP. In the absence of such evidence, the clinical use of these forms of treatment is not justified and should be discouraged. (Seco, 2011)" Guidelines recommend against the use of electric shockwave therapy for the lumbar spine. As such, the request for Extracorporeal Shockwave Therapy x 7 treatments for the lumbar spine is not medically necessary.