

Case Number:	CM15-0108634		
Date Assigned:	06/12/2015	Date of Injury:	11/21/2014
Decision Date:	07/14/2015	UR Denial Date:	05/18/2015
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: California
 Certification(s)/Specialty: Physical Medicine & Rehabilitation

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. The current diagnoses are lumbosacral sprain/strain and lumbar intervertebral disc displacement without myelopathy. According to the progress report dated 5/11/2015, the injured worker complains of constant, moderate low back and bilateral gluteal pain. The pain is associated with numbness in the bilateral lower extremities. The level of pain is not rated. The physical examination reveals range of motion restrictions, tenderness, paraspinal edema, and muscle guarding at the involved levels. The current medication list is not available for review. Treatment to date has included medication management, MRI studies, and physical therapy. The plan of care includes 3 chiropractic, myofascial release, and electrical stimulation sessions to the lumbar spine.

IMR ISSUES, DECISIONS AND RATIONALES

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

Chiropractic treatments for 3 visits 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 Chiropractic Care, Manual Therapy & Manipulation, Treatment, Pages 58-60.

Decision rationale: MTUS Guidelines supports manual therapy for musculoskeletal injury. The intended goal is the achievement of positive musculoskeletal conditions via positive symptomatic or objective measurable gains in functional improvement that facilitate progression in the patient's therapeutic exercise program and return to productive activities. From records review, it is unclear how many sessions have been completed. Per medicals reviewed, the patient has received a significant quantity of manual sessions for the chronic symptom complaints without demonstrated functional improvement from treatment already rendered. There is no report of acute flare-ups, red-flag conditions or new clinical findings to support continued treatment consistent with guidelines criteria. The Chiropractic treatments for 3 visits for the lumbar spine is not medically necessary and appropriate.

Myofascial release for 3 visits 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 Myofascial/TPI, page 122.

Decision rationale: Myofascial therapy is recommended for time-limited use in subacute and chronic pain patients without underlying serious pathology and as an adjunct to a conditioning program that has both graded aerobic exercise and strengthening exercises; however, this is not the case for this chronic injury status post significant conservative therapy currently on an independent home exercise program without plan for formal therapy sessions. The patient has received a significant amount of multiple treatment modalities without any specific change in chronic symptom complaints, clinical findings, and functional status. A short course may be appropriate during an acute flare-up; however, no new injury or flare is reported nor is there any demonstrated clinical change or functional improvement from treatment rendered previously for this chronic injury. Without any new onset or documented plan for a concurrent active exercise program, criteria for myofascial therapy have not been established per MTUS Chronic Pain Guidelines. The Myofascial release for 3 visits for the lumbar spine is not medically necessary and appropriate.

Electrical stimulation for 3 visits for the lumbar spine: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 300, Chronic Pain Treatment Guidelines Physical Medicine.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Transcutaneous Electrotherapy, TENS for chronic pain, pages 114-117.

Decision rationale: Per MTUS Chronic Pain Treatment Guidelines, ongoing treatment is not advisable if there are no signs of objective progress and functional restoration has not been

demonstrated. Specified criteria for electrical stimulation include trial in adjunction to ongoing treatment modalities within the functional restoration approach as appropriate for documented chronic intractable pain of at least three months duration with failed evidence of other appropriate pain modalities tried such as medication. From the submitted reports, the patient has received extensive conservative medical treatment to include chronic analgesics and other medication, extensive physical therapy, activity modifications, yet the patient has remained symptomatic and functionally impaired. There is no documentation on how or what electrical stim unit is used nor is there any documented short-term or long-term goals of treatment. There is no evidence for change in functional status, increased in ADLs, decreased VAS score, medication usage, or treatment utilization from the treatment already rendered. The Electrical stimulation for 3 visits for the lumbar spine is not medically necessary and appropriate.