

Case Number:	CM15-0130274		
Date Assigned:	07/16/2015	Date of Injury:	10/01/2013
Decision Date:	08/19/2015	UR Denial Date:	06/23/2015
Priority:	Standard	Application Received:	07/06/2015

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, Pain Management

CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

This 33-year-old male sustained an industrial injury on 10/01/13. He subsequently reported pain in the low back, legs and knees. Diagnoses include lumbosacral sprain. Treatments to date include nerve conduction testing and prescription pain medications. The injured worker continues to experience low back pain to the bilateral lower extremities. Upon examination, there was decreased range of motion in the lumbosacral spine and antalgic gait noted. A request for myofascial release, Physiotherapy Mechanical traction, Electro-stimulation for Low & Upper Back, 2 times wkly for 3 wks, 6 sessions and pain management consultation was made by the treating physician.

IMR ISSUES, DECISIONS AND RATIONALES

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

Myofacial release: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Massage therapy.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 60 of 127. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain Chapter, Massage Therapy.

Decision rationale: Regarding the request for Myofascial release, Chronic Pain Medical Treatment Guidelines state the massage therapy is recommended as an option. They go on to state the treatment should be an adjunct to other recommended treatment (e.g. exercise), and it should be limited to 4 to 6 visits in most cases. Within the documentation available for review, there is no indication as to the number of massage therapy visits the patient has previously undergone. Additionally, there is no indication that the currently requested massage therapy will be used as an adjunct to other recommended treatment modalities. Finally, the current request does not include a frequency of visits or duration of treatment. Guidelines do not support the open-ended application of any treatment modality, and there is no provision to modify the current request. As such, the currently requested Myofascial release is not medically necessary.

Physiotherapy Mechanical traction: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 298, Chronic Pain Treatment Guidelines Page(s): 98 of 127. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back Chapter, Physical Therapy.

Decision rationale: Regarding the request for Physiotherapy Mechanical traction, Chronic Pain Medical Treatment Guidelines recommend a short course of active therapy with continuation of active therapies at home as an extension of the treatment process in order to maintain improvement levels. ODG has more specific criteria for the ongoing use of physical therapy. ODG recommends a trial of physical therapy. If the trial of physical therapy results in objective functional improvement, as well as ongoing objective treatment goals, then additional therapy may be considered. Within the documentation available for review, there is no indication of any specific objective treatment goals and no statement indicating why an independent program of home exercise would be insufficient to address any objective deficits. Finally, the current request does not include a frequency of visits or duration of treatment. Guidelines do not support the open-ended application of any treatment modality, and there is no provision to modify the current request. As such, the current request for Physiotherapy Mechanical traction is not medically necessary.

Electro-stimulation for Low & Upper Back, 2 times wkly for 3 wks, 6 sessions: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Transcutaneous electrotherapy.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page 114-121 of 127.

Decision rationale: Regarding the request for Electro-stimulation for Low & Upper Back, 2 times wkly for 3 wks, 6 sessions, Chronic Pain Medical Treatment Guidelines state that transcutaneous electrical nerve stimulation (TENS) is 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. Guidelines recommend failure of other appropriate pain modalities including medications prior to a TENS unit trial. Prior to TENS unit purchase, one month trial 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. Within the documentation available for review, there is no indication that the patient has undergone a TENS unit trial, and no documentation of any specific objective functional deficits which Electro-stimulation would be intended to address. Additionally, it is unclear what other treatment modalities are currently being used within a functional restoration approach. Finally, it is unclear why 6 sessions would be required, as opposed to the 30-day trial recommended by guidelines. In the absence of clarity regarding those issues, the currently requested Electro-stimulation for Low & Upper Back, 2 times wkly for 3 wks, 6 sessions unit is not medically necessary.

Pain Management consultation: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Functional Improvement Page(s): 31.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation American College of Occupational and Environmental Medicine (ACOEM), 2nd Edition, (2004) Occupational Medicine Practice Guidelines, Independent Medical Examinations and Consultations Chapter, Page 127 Other Medical Treatment Guideline or Medical Evidence: State of Colorado, Chronic Pain Disorder Medical Treatment Guidelines, Exhibit Page Number 52.

Decision rationale: Regarding the request for referral to pain management for consultation and treatment, California MTUS does not address this issue. ACOEM supports consultation if a diagnosis is uncertain or extremely complex, when psychosocial factors are present, or when the plan or course of care may benefit from additional expertise. Within the documentation available for review, the patient has ongoing pain corroborated by physical exam findings. However, it is unclear exactly why pain management consultation is being requested. The patient's current physician seems to have additional conservative treatment options and there is no discussion regarding any interventional treatments being sought. In light of the above issues, the currently requested referral to pain management for consultation and treatment is not medically necessary.