

Case Number:	CM15-0164173		
Date Assigned:	09/01/2015	Date of Injury:	03/24/2015
Decision Date:	10/14/2015	UR Denial Date:	08/11/2015
Priority:	Standard	Application Received:	08/21/2015

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 27 year old man sustained an industrial injury on 3-24-2015. The mechanism of injury is not detailed. Diagnoses include headache, thoracic spine muscle spasm, thoracic spine pain, lumbar spine myofasciitis, lumbar spine pain, lumbar radiculopathy, sleep disturbance, psychiatric component, and chronic pain. Treatment has included oral medications. Physician notes on a PR-2 dated 7-9-2015 show complaints of thoracic spine pain, and lumbar spine pain rated 9 out of 10, and loss of sleep due to pain. Physical examination revealed decreased range of motion with tenderness in the lumbar spine and appeared to grow muscles. No sensory or motor examination was performed. Recommendations include nerve conduction studies, manipulative therapy, acupuncture, physio-therapeutic treatments, orthopedic evaluation, psychosocial evaluation, internal medicine evaluation, shockwave therapy, periodic urine drug screen, LidoPro ointment, Diclofenac, omeprazole, brace or support, hot and cold device, interferential therapy unit, home exercise program, modifications for daily activities and work, functional capacity evaluation, and sleep studies. Notes indicate that the patient has undergone 3-6 sessions of chiropractic therapy. Additionally, it appears the patient has undergone physical therapy previously.

IMR ISSUES, DECISIONS AND RATIONALES

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

Shockwave 1 time per week for 6 weeks for lumbar: Upheld

Claims Administrator guideline: Decision based on MTUS Low Back Complaints 2004, and Chronic Pain Medical Treatment 2009. Decision based on Non-MTUS Citation Official Disability Guidelines, Low Back Chapter: Shockwave 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 Chapter, Shock wave therapy.

Decision rationale: Regarding the request for ESWT for lumbar spine, California MTUS does not address the issue. ODG cites that it is not recommended for the lumbar spine as the available evidence does not support its effectiveness in treating low back pain. As such, the currently requested ESWT for lumbar spine is not medically necessary.

EMG/NCV LE: Upheld

Claims Administrator guideline: Decision based on MTUS Low Back Complaints 2004. Decision based on Non-MTUS Citation Official Disability Guidelines, Low Back Chapter.

MAXIMUS guideline: Decision based on MTUS Low Back Complaints 2004, Section(s): Special Studies. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back Chapter, Electrodiagnostic Studies.

Decision rationale: Regarding the request for EMG/NCV of the lower extremities, Occupational Medicine Practice Guidelines state that unequivocal objective findings that identify specific nerve compromise on the neurologic exam are sufficient evidence to warrant imaging in patients who do not respond to treatment and who would consider surgery. When a neurologic examination is less clear however, further physiologic evidence of nerve dysfunction should be obtained before ordering an imaging study. They go on to state that electromyography may be useful to identify subtle focal neurologic dysfunction in patients with low back symptoms lasting more than 3 to 4 weeks. ODG states that nerve conduction studies are not recommended for back conditions. They go on to state that there is minimal justification for performing nerve conduction studies when a patient is presumed to have symptoms on the basis of radiculopathy. Within the documentation available for review, there are no physical examination findings supporting a diagnosis of specific nerve compromise. Additionally, if such findings are present but have not been documented, there is no documentation that the patient has failed conservative treatment directed towards these complaints. In the absence of such documentation, the currently requested EMG/NCV of the lower extremities is not medically necessary.

Chiropractic sessions 1 time per week for 6 weeks for lumbar: Upheld

Claims Administrator guideline: Decision based on MTUS Low Back Complaints 2004, and Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Manual therapy & manipulation.

Decision rationale: Regarding the request for additional chiropractic care, Chronic Pain Medical Treatment Guidelines support the use of chiropractic care for the treatment of chronic pain caused by musculoskeletal conditions. Guidelines go on to recommend a trial of up to 6 visits over 2 weeks for the treatment of low back pain. With evidence of objective functional improvement, a total of up to 18 visits over 6 to 8 weeks may be supported. Within the

documentation available for review, there is documentation of completion of prior chiropractic sessions, but there is no documentation of specific objective functional improvement with the previous sessions and remaining deficits that cannot be addressed within the context of an independent home exercise program, yet are expected to improve with formal supervised therapy. In the absence of clarity regarding the above issues, the currently requested chiropractic care is not medically necessary.

Physiotherapy sessions 1 time per week for 6 weeks for lumbar: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009. Decision based on Non-MTUS Citation Official Disability Guidelines, Low Back Chapter: Physical Therapy.

MAXIMUS guideline: Decision based on MTUS Low Back Complaints 2004, Section(s): Physical Methods, and Chronic Pain Medical Treatment 2009, Section(s): Physical Medicine. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back Chapter, Physical Therapy.

Decision rationale: Regarding the request for additional physical therapy, 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 documentation of completion of prior PT sessions, but there is no documentation of specific objective functional improvement with the previous sessions and remaining deficits that cannot be addressed within the context of an independent home exercise program, yet are expected to improve with formal supervised therapy. Furthermore, it is unclear how many therapy sessions the patient has already undergone making it impossible to determine if the patient has exceeded the maximum number recommended by guidelines for their diagnosis. In light of the above issues, the currently requested additional physical therapy is not medically necessary.