

Case Number:	CM15-0168624		
Date Assigned:	09/09/2015	Date of Injury:	11/19/1984
Decision Date:	10/26/2015	UR Denial Date:	08/20/2015
Priority:	Standard	Application Received:	08/27/2015

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: Arizona, Michigan

Certification(s)/Specialty: Preventive Medicine, Occupational 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 55-year-old male, with a reported date of injury of 11-19-1984. The diagnoses include cervical spine sprain, thoracic spine sprain, and lumbar spine sprain. Treatments and evaluation to date have included chiropractic treatment and H-wave unit. The diagnostic studies to date were not included in the medical records. The progress report dated 08-12-2015 is handwritten and somewhat illegible. The report indicates that the injured worker had cervical, thoracic, and lumbar spine pain, which was rated 7 out of 10. The objective findings included decreased range of motion of the cervical, thoracic, and lumbar spine; spasms; decreased lower extremity strength due to low back pain; and cervical range of motion pain with bilateral trapezii and upper thoracic spine. It was noted that the injured worker had received 13 visits, and 3 re-examinations from 01-01-2015. The injured worker was seen on an as needed basis. The injured worker noted decreased pain with chiropractic treatment and home H-wave use. The request for authorization was not included in the medical records. On 08-06-2015, the Utilization Review non-certified the request for three specific spinal adjustments due to the absence of quantified documentation of specific objective functional improvement as a result of the previous chiropractic visits, three infrared therapy since the guidelines do not support this as a stand-alone primary treatment modality, three myofascial release since the guidelines limit this treatment to four to six visits, one post treatment re-examination since the additional chiropractic treatment was recommended to be non-certified, and three electrical stimulations since the guidelines do not support this as a stand-alone primary treatment modality.

IMR ISSUES, DECISIONS AND RATIONALES

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

3 specific spinal adjustments: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

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

Decision rationale: Manual Therapy is recommended for chronic pain if caused by musculoskeletal conditions per the MTUS. Manual Therapy is widely used in the treatment of musculoskeletal pain. The intended goal or effect of Manual Medicine is the achievement of positive symptomatic or objective measurable gains in functional improvement that facilitate progression in the patient's therapeutic exercise program and return to productive activities. Manipulation is manual therapy that moves a joint beyond the physiologic range-of-motion but not beyond the anatomic range-of-motion. 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. However a review of the injured workers medical records that are available to me and which are mostly illegible do not reveal any documentation of improvement in pain or function with the use previous chiropractic care, therefore the request for 3 specific spinal adjustments is not medically necessary.

3 infrared therapy: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back & Lumbar & Thoracic (Acute & Chronic) Infrared IR (2015).

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) / Infrared therapy (IR).

Decision rationale: The MTUS /ACOEM did not address the use of infrared therapy, therefore other guidelines were consulted. Per the ODG, infrared therapy is 'not recommended over other heat therapies. Where deep heating is desirable, providers may consider a limited trial of IR therapy for treatment of acute LBP, but only if used as an adjunct to a program of evidence-based conservative care (exercise). The IR therapy unit used in this trial was demonstrated to be effective in reducing chronic low back pain, and no adverse effects were observed; the IR group experienced a 50% pain reduction over 7 weeks, compared with 15% in the sham group." Unfortunately, any type of heat therapy is typically part of evidenced based conservative care such as physical therapy and not usually requested separately, therefore the request for 3 infrared therapy is not medically necessary.

3 myofascial release: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Hip & Pelvis (Acute & Chronic) / Active release technique (ART) manual therapy.

Decision rationale: The MTUS does not address the use of myofascial release, therefore other guidelines were consulted. Per the ODG, it is "under study. While this is one of many possible techniques used in manual therapy, there are no specific high quality published studies to support use of Active Release Technique (ART), although there may be anecdotal information. In general, manual therapy, whether by physical therapists or by chiropractors, is a recommended treatment for many conditions in ODG. ART is a soft tissue massage technique developed and patented by [REDACTED]. It is most commonly used to treat conditions related to adhesions or scar tissue in overused muscles. According to ART practitioners, as adhesions build up, muscles become shorter and weaker, the motion of muscles and joints are altered, and nerves can be compressed. As a result, tissues suffer from decreased blood supply, pain, and poor mobility. The goal of ART is to restore the smooth movement of tissues and to release any entrapped nerves or blood vessels. In an ART treatment, the provider uses his or her hands to evaluate the texture, tightness and mobility of the soft tissue. Using hand pressure, the practitioner works to remove or break up the fibrous adhesions, with the stretching motions generally in the direction of venous and lymphatic flow. In the first three levels of ART treatment, the practitioner does movement of the patient's tissue. In level four, however, ART requires the patient to actively move the affected tissue in prescribed ways while the practitioner applies pressure. Involvement of the patient is seen as an advantage of ART, as people who are active participants in their own healthcare are believed to experience better outcomes. The application of ART specifically to treat groin strains may be of benefit in increasing pain thresholds, but further research is required to validate the therapeutic effect of ART." Unfortunately, any type of manual therapy is typically part of evidenced based conservative care such as physical therapy or chiropractic care and not usually requested separately, therefore the request for 3 myofascial release is not medically necessary.

1 post treatment re-examination: Upheld

Claims Administrator guideline: Decision based on MTUS Low Back Complaints 2004. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain (Chronic) Office Visits 2015.

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

Decision rationale: Manual Therapy is recommended for chronic pain if caused by musculoskeletal conditions per the MTUS. Manual Therapy is widely used in the treatment of

musculoskeletal pain. The intended goal or effect of Manual Medicine is the achievement of positive symptomatic or objective measurable gains in functional improvement that facilitate progression in the patient's therapeutic exercise program and return to productive activities. Manipulation is manual therapy that moves a joint beyond the physiologic range-of-motion but not beyond the anatomic range-of-motion. 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. However a review of the injured workers medical records that are available to me and which are mostly illegible do not reveal any documentation of improvement in pain or function with the use previous chiropractic care, therefore the request for 3 specific spinal adjustments is not medically necessary. Since the injured worker is not getting additional manual therapy, the request for 1 post treatment re-examination is also not medically necessary.

3 electrical stimulations: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

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

Decision rationale: Manual Therapy is recommended for chronic pain if caused by musculoskeletal conditions per the MTUS. Manual Therapy is widely used in the treatment of musculoskeletal pain. The intended goal or effect of Manual Medicine is the achievement of positive symptomatic or objective measurable gains in functional improvement that facilitate progression in the patient's therapeutic exercise program and return to productive activities. Manipulation is manual therapy that moves a joint beyond the physiologic range-of-motion but not beyond the anatomic range-of-motion. 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. Unfortunately, any E-Stim is typically part of evidenced based conservative care such as physical therapy or chiropractic care and not usually requested separately, therefore the request for 3 electrical stimulations is not medically necessary.