

Case Number:	CM15-0181642		
Date Assigned:	09/22/2015	Date of Injury:	12/27/1999
Decision Date:	12/02/2015	UR Denial Date:	08/14/2015
Priority:	Standard	Application Received:	09/15/2015

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: Emergency 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:

This 39 year old woman sustained an industrial injury on 12-27-1999. Diagnoses include cervical and lumbar spine intervertebral disc syndrome, bilateral upper and lower extremity radicular syndrome, and intersegmental dysfunction. Treatment has included oral medications. Physician notes dated 7-27-2015 show complaints of exacerbation of neck and upper back pain with numbness and tingling to the bilateral hands, and secondary low back pain with left sciatica. The physical examination shows cervical range of motion 33% decreased and painful, lumbar spine range of motion is noted to be 25% decreased and painful, positive straight leg raise at 45 degrees, lumbar paraspinal spasms, multiple level of segmental fixation were noted, and deep tendon reflexes were trace throughout. Recommendations include spinal manipulation, ultrasound, electrical stimulation, traction, myofascial release, updated cervical and lumbosacral x-rays and MRIs, and possible electrodiagnostic studies pending results of the MRIs.

IMR ISSUES, DECISIONS AND RATIONALES

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

Spinal manipulation Qty: 1.00: 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: The requested Spinal manipulation Qty: 1.00 is not medically necessary. CA MTUS Chronic Pain Treatment Guidelines, Manual Therapy and Manipulation, Pages 58-59, recommend continued chiropractic therapy with documented objective evidence of derived functional benefit. The injured worker has neck and upper back pain with numbness and tingling to the bilateral hands and secondary low back pain with left sciatica. The physical examination shows cervical range of motion 33% decreased and painful, lumbar spine range of motion is noted to be 25% decreased and painful, positive straight leg raise at 45 degrees, lumbar paraspinal spasms, multiple level of segmental fixation were noted, and deep tendon reflexes were trace throughout. The treating physician has not documented objective evidence of derived functional benefit from completed chiropractic sessions, such as improvements in activities of daily living, reduced work restrictions or reduced medical treatment dependence. The criteria noted above not having been met, Spinal manipulation Qty: 1.00 is not medically necessary.

Ultrasound electrical Qty: 1.00: 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): Ultrasound, therapeutic.

Decision rationale: The requested Ultrasound electrical Qty: 1.00 is not medically necessary. CA Medical Treatment Utilization Schedule (MTUS), Chronic Pain Medical Treatment Guidelines, July 18, 2009P 123, Ultrasound, therapeutic noted: "Not recommended." Therapeutic ultrasound is one of the most widely and frequently used electrophysical agents. Despite over 60 years of clinical use, the effectiveness of ultrasound for treating people with pain, musculoskeletal injuries, and soft tissue lesions remains questionable. There is little evidence that active therapeutic ultrasound is more effective than placebo ultrasound for treating people with pain or a range of musculoskeletal injuries or for promoting soft tissue healing. (Robertson, 2001). The injured worker has neck and upper back pain with numbness and tingling to the bilateral hands and secondary low back pain with left sciatica. The physical examination shows cervical range of motion 33% decreased and painful, lumbar spine range of motion is noted to be 25% decreased and painful, positive straight leg raise at 45 degrees, lumbar paraspinal spasms, multiple level of segmental fixation were noted, and deep tendon reflexes were trace throughout. The treating physician has not documented subjective or objective findings indicative of functional improvement from previous treatments. The criteria noted above not having been met, Ultrasound electrical Qty: 1.00 to resolve this exacerbation is not medically necessary.

Traction Qty: 1.00: Upheld

Claims Administrator guideline: Decision based on MTUS Neck and Upper Back Complaints 2004, Low Back Complaints 2004, and Chronic Pain Medical Treatment 2009. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low back -

lumbar & Thoracic Official Disability Guidelines (ODG), Neck and Upper back chapter - traction.

MAXIMUS guideline: Decision based on MTUS Neck and Upper Back Complaints 2004, Section(s): Summary.

Decision rationale: The requested Traction Qty: 1.00 is not medically necessary. CA MTUS, ACOEM 2nd Edition, 2004, Chapter 8, Neck and Upper Back Complaints, Special Studies and Diagnostic and Therapeutic Considerations, Page 181, does not recommend cervical traction. The injured worker has neck and upper back pain with numbness and tingling to the bilateral hands and secondary low back pain with left sciatica. The physical examination shows cervical range of motion 33% decreased and painful, lumbar spine range of motion is noted to be 25% decreased and painful, positive straight leg raise at 45 degrees, lumbar paraspinal spasms, multiple level of segmental fixation were noted, and deep tendon reflexes were trace throughout. The treating physician has not documented subjective or objective findings indicative of cervical radiculopathy, nor objective evidence of derived functional benefit from the use of cervical traction under the supervision of a licensed physical therapist. The criteria noted above not having been met, Traction Qty: 1.00 to resolve this exacerbation is not medically necessary.

Myofascial release Qty: 1.00: 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): Massage therapy.

Decision rationale: The requested Myofascial release Qty: 1.00 is not medically necessary. CA Medical Treatment Utilization Schedule (MTUS) 2009: Chronic Pain Treatment Guidelines, Page 60, Massage therapy, recommends massage therapy as an option and "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." The injured worker has neck and upper back pain with numbness and tingling to the bilateral hands and secondary low back pain with left sciatica. The physical examination shows cervical range of motion 33% decreased and painful, lumbar spine range of motion is noted to be 25% decreased and painful, positive straight leg raise at 45 degrees, lumbar paraspinal spasms, multiple level of segmental fixation were noted, and deep tendon reflexes were trace throughout. The treating physician has not documented the injured worker's participation in a dynamic home exercise program or other programs involving aerobic and strengthening exercise. The criteria noted above not having been met, Myofascial release Qty: 1.00 is not medically necessary.

6 treatments over 3-4 weeks to resolve this exacerbation: 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: The requested 6 treatments over 3-4 weeks to resolve this exacerbation, is not medically necessary. CA MTUS Chronic Pain Treatment Guidelines, Manual Therapy and Manipulation, Pages 58-59, recommend continued chiropractic therapy with documented objective evidence of derived functional benefit. The injured worker has neck and upper back pain with numbness and tingling to the bilateral hands and secondary low back pain with left sciatica. The physical examination shows cervical range of motion 33% decreased and painful, lumbar spine range of motion is noted to be 25% decreased and painful, positive straight leg raise at 45 degrees, lumbar paraspinal spasms, multiple level of segmental fixation were noted, and deep tendon reflexes were trace throughout. The treating physician has not documented objective evidence of derived functional benefit from completed chiropractic sessions, such as improvements in activities of daily living, reduced work restrictions or reduced medical treatment dependence. The criteria noted above not having been met, 6 treatments over 3-4 weeks to resolve this exacerbation is not medically necessary.

Updated cervical and lumbosacral X-rays/MRIs: Upheld

Claims Administrator guideline: Decision based on MTUS Neck and Upper Back Complaints 2004, and Low Back Complaints 2004. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Neck and Upper back chapter - X-ray Official Disability Guidelines (ODG), Low back chapter.

MAXIMUS guideline: Decision based on MTUS Neck and Upper Back Complaints 2004, Section(s): Special Studies.

Decision rationale: The requested Updated cervical and lumbosacral X-rays/MRIs, is not medically necessary. American College of Occupational and Environmental Medicine (ACOEM), 2nd Edition, (2004), Chapter 12, Neck and Upper Back Complaints, Special Studies and Diagnostic and Treatment Considerations, Page 178-179, recommend radiographs only with documented red flag conditions, after conservative treatment trials. The injured worker has neck and upper back pain with numbness and tingling to the bilateral hands and secondary low back pain with left sciatica. The physical examination shows cervical range of motion 33% decreased and painful, lumbar spine range of motion is noted to be 25% decreased and painful, positive straight leg raise at 45 degrees, lumbar paraspinal spasms, multiple level of segmental fixation were noted, and deep tendon reflexes were trace throughout. The treating physician has not documented applicable red flag conditions. The criteria noted above not having been met, Updated cervical and lumbosacral X-rays/MRIs to resolve this exacerbation is not medically necessary.