

Case Number:	CM15-0198062		
Date Assigned:	10/16/2015	Date of Injury:	05/25/2015
Decision Date:	12/01/2015	UR Denial Date:	09/03/2015
Priority:	Standard	Application Received:	10/08/2015

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: Maryland, Texas, Virginia

Certification(s)/Specialty: Internal Medicine, Allergy and Immunology, Rheumatology

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 56 year old female, who sustained an industrial injury on 5-25-15. She reported back pain. The injured worker was diagnosed as having lumbosacral sprain and strain, thoracic sprain and strain, and lateral collateral ligament sprain and strain. Treatment to date has included chiropractic treatment, an unknown number of physical therapy session, and medication including Naproxen, Tramadol, Zanaflex, and topical compound creams. Physical examination findings on 6-15-15 included tenderness and spasm over the lumbar paravertebral muscles and bilateral sacroiliac joints. Kemps test was positive bilaterally and Braggard's test was positive on the left for radiating pain. Hypoesthesia was noted at L3-S1. On 8-24-15, the injured worker complained of mid-back and low back pain rated as 4-5 of 10. On 8-24-15 the treating physician requested authorization for manual therapy 3x4 for the lumbar spine and EMS infrared 3x4 for the thoracic spine.

IMR ISSUES, DECISIONS AND RATIONALES

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

Manual therapy 3 times a week for 4 weeks for lumbar spine: Upheld

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

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

Decision rationale: California MTUS guidelines refer to physical medicine guidelines for physical therapy and recommends as follows: "Allow for fading of treatment frequency (from up to 3 visits per week to 1 or less), plus active self-directed home Physical Medicine." Additionally, ACOEM guidelines advise against passive modalities by a therapist unless exercises are to be carried out at home by patient. ODG quantifies its recommendations with 10 visits over 8 weeks for lumbar sprains/strains and 9 visits over 8 weeks for unspecified backache/lumbago. ODG further states that a "six-visit clinical trial" of physical therapy with documented objective and subjective improvements should occur initially before additional sessions are to be warranted. Medical records fail to indicate initial trial used. The UR modified the request to allow for 6 sessions. As such, the request for Manual therapy 3 times a week for 4 weeks for lumbar spine is not medically necessary.

EMS Infrared 3 times a week for 4 weeks for Thoracic spine: Upheld

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

MAXIMUS guideline: Decision based on MTUS Neck and Upper Back Complaints 2004, Section(s): Initial Care. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Neck and Upper Back (Acute & Chronic), Pain, Heat/cold applications.

Decision rationale: The request is an electronic heating pad with various heat settings. ACOEM and ODG comment on heat/cold packs, "Recommended. Insufficient testing exists to determine the effectiveness (if any) of heat/cold applications in treating mechanical neck disorders, though due to the relative ease and lack of adverse affects, local applications of cold packs may be applied during first few days of symptoms followed by applications of heat packs to suit patient." The guidelines appear to recommend short-term use of heat application within the first few days of injury. The patient is significantly past the "acute" phase of the injury. Medical documents do not substantiate the necessity of the product now. The UR modified the request to allow for 6 sessions. As such, the request for EMS infrared 3 times a week for 4 weeks for Thoracic spine is not medically necessary.