

Case Number:	CM13-0050701		
Date Assigned:	12/27/2013	Date of Injury:	04/01/2012
Decision Date:	03/19/2014	UR Denial Date:	11/01/2013
Priority:	Standard	Application Received:	11/14/2013

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Occupational Medicine, and is licensed to practice in California. 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 physician 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

CLINICAL CASE SUMMARY

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

According to the records made available for review, this is a 31-year-old male with a 4/1/12 date of injury. At the time of request for authorization for Chiro one (1) time a week for four (4) weeks, Localized intense neurostimulation therapy for six (6) session, and Physical Therapy (PT) two (2) times a week for four (4) weeks, there is documentation of subjective (constant, dull, achy, sharp low back pain with stiffness and tingling, and weakness in the lower extremities) and objective (restricted range of motion, tenderness to palpation of the lumbar paravertebral muscles, muscle spasms, and positive straight leg raise) findings, current diagnoses (lumbar disc protrusion, lumbar musculoligamentous injury, lumbar myospasm, lumbar radiculopathy, and elevated blood pressure), and treatment to date (activity modification, TENS, physical therapy, and medications). The 7/8/13 medical report indicates that the patient has been undergoing physiotherapy, acupuncture, and chiropractic treatments, which have been helpful. There is no documentation of the number of previous chiropractic treatments and previous physical therapy sessions completed to date, and a history of a stroke.

IMR ISSUES, DECISIONS AND RATIONALES

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

Chiro one (1) time a week for four (4) weeks: Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 298-299, Chronic Pain Treatment Guidelines Section Manual Therapy & Manipulation Page(s): 58.

Decision rationale: The MTUS reference to ACOEM identifies documentation of objective improvement with previous treatment, functional deficits, functional goals, and a statement identifying why an independent home exercise program would be insufficient to address any remaining functional deficits as criteria necessary to support the medical necessity of additional chiropractic treatment. In addition, MTUS Chronic Pain Medical Treatment Guidelines supports a total of up to 18 visits over 6-8 weeks. Within the medical information available for review, there is documentation of diagnoses of lumbar disc protrusion, lumbar musculoligamentous injury, lumbar myospasm, and lumbar radiculopathy. In addition, there is documentation of objective improvement with previous treatment, functional deficits, and functional goals. However, there is no documentation of the number of previous chiropractic treatments and, if the number of treatments have already exceeded guidelines, a statement why any residual deficits cannot be resolved in the context of a home exercise program. Therefore, based on guidelines and a review of the evidence, the request for Chiro one (1) time a week for four (4) weeks is not medically necessary.

Localized intense neurostimulation therapy for six (6) sessions: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation "A Novel Image-Guided, Automatic, High-Intensity Neurostimulation Device for the Treatment of Nonspecific Low Back Pain", Pain Research and Treatment, Vol. 2011, Article ID 152307.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Section Neuromuscular Electrical Stimulation Page(s): 121.

Decision rationale: The MTUS Chronic Pain Medical Treatment Guidelines indicate that neuromuscular electrical stimulation (NMES) is not recommended. In addition, the MTUS Chronic Pain Medical Treatment Guidelines indicate that NMES is primarily used as part of a rehabilitation program following stroke and there is no evidence to support its use in chronic pain. Within the medical information available for review, there is documentation of diagnoses of lumbar disc protrusion, lumbar musculoligamentous injury, lumbar myospasm, and lumbar radiculopathy. However, there is no documentation of a history of stroke. Therefore, based on guidelines and a review of the evidence, the request for Localized intense neurostimulation therapy for six (6) sessions is not medically necessary.

Physical Therapy (PT) Two (2) times a week for four (4) weeks: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Pain, Suffering and the Restoration of Function Chapter (ACOEM Practice Guidelines, 2nd Edition (2004)) pg. 114.

Decision rationale: The MTUS reference to ACOEM identifies the importance of a time-limited treatment plan with clearly defined functional goals, with frequent assessment and modification of the treatment plan based upon the patient's progress in meeting those goals. The ODG recommends a limited course of physical therapy for patients with a diagnosis of lumbar radiculopathy not to exceed 12 sessions over 8 weeks; and documentation of exceptional factors when treatment duration and/or number of visits exceeds the guidelines. Within the medical information available for review, there is documentation of diagnoses of lumbar disc protrusion, lumbar musculoligamentous injury, lumbar myospasm, and lumbar radiculopathy. In addition, there is documentation of previous physical therapy sessions completed to date with objective improvement. However, there is no documentation of the number of previous physical therapy sessions completed and, if the number of treatments have already exceeded guidelines, documentation of exceptional factors. Therefore, based on guidelines and a review of the evidence, the request for Physical Therapy (PT) two (2) times a week for four (4) weeks is not medically necessary.