

Case Number:	CM14-0163470		
Date Assigned:	10/08/2014	Date of Injury:	04/18/2014
Decision Date:	11/04/2014	UR Denial Date:	09/04/2014
Priority:	Standard	Application Received:	10/04/2014

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. The expert reviewer is Board Certified in Physical Medicine and Rehabilitation, has a subspecialty in Interventional Spine 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 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/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:

The patient is a 29 year old female with an injury date of 04/18/14. The 08/20/14 progress report by [REDACTED] states that the patient presents with occasional lower back pain radiating to the left leg. The patient is to return to modified work. Examination reveals there is tenderness to palpation of the lumbar paravertebral muscles with spasm. Milgram's causes pain. The patient's diagnoses include: Lumbar radiculopathy Lumbar sprain/strain The utilization review being challenged is dated 09/04/14. Reports were provided from 04/24/14 to 08/20/14.

IMR ISSUES, DECISIONS AND RATIONALES

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

Chiropractic x 4 sessions, lumbar spine: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Manual therapy and manipulation.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Manual Therapy and Manipulation, for chronic pain Page(s): 58, 59.

Decision rationale: The patient presents with occasional lower back pain radiating to the left leg. The treater requests for Chiropractic times four sessions lumbar spine. California Medical Treatment Utilization Schedule (MTUS) Manual Therapy and Manipulation guidelines pages 58,

59 state that treatment is recommended for chronic pain if caused by musculoskeletal conditions. For the low back it is recommended as an option. For Therapeutic care - A trial of 6 visits over 2 weeks, with evidence of objective functional improvement, with a total of up to 18 visits over 6-8 weeks is allowed. The treater does not discuss the reason for the request in the reports provided. Chiropractic treatment reports were provided for 4 sessions for lumbar treatment from 06/24/14 to 07/08/14. These reports do not document functional improvement in the patient. The utilization review cites Chiropractic treatment notes dated 08/08/14 and mentions 9 chiropractic visits. In this case, California MTUS allows a trial of 6 visits with a total of up to 18 visits with evidence of functional improvement. If the 4 requested visits are part of the trial, the number of visits requested combined with the at least 4 sessions completed exceed what is allowed by California MTUS. If the request is for additional visits following a trial, the chiropractic and treatment reports provided lack documentation of functional improvement. The treatment is not medically necessary and appropriate.

Shockwave therapy x 6 lumbar spine: 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), ODG-TWC Low Back Procedure Summary

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) ODG guidelines Knee & Leg, Shoulder, Elbow, Ankle and Foot Chapters, ESWT Topic

Decision rationale: The patient presents with occasional lower back pain radiating to the left leg. The treater requests for Shockwave therapy times six for the lumbar spine. The treater states peer reviewed scientific and medical evidence shows the efficacy of ESWT in treating the musculoskeletal condition(s) the patient suffers from. Official Disability Guidelines (ODG) guidelines Knee & Leg, Shoulder, Elbow, Ankle and Foot Chapters, ESWT Topic address extracorporeal shockwave treatment. ODG states it is shock treatment indicated for such conditions as calcific tendinitis of shoulder, epicondylitis and plantar fasciitis. The treatment is not intended for spinal conditions or myofascial pain. The treatment is not medically necessary and appropriate.

EMG bilateral lowr extremities: Overturned

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303.

Decision rationale: The patient presents with occasional lower back pain radiating to the left leg. The treater requests for Electromyography (EMG) bilateral lower extremities. ACOEM guidelines page 303 states, "Electromyography (EMG), including H-reflex tests, may be useful to identify subtle, focal neurologic dysfunction in patients with low back symptoms lasting more

than three or four weeks." This patient does present with low back pain. There is no reference to prior EMG studies. The request appears reasonable and supported by ACOEM. The treatment is medically necessary and appropriate.