

Case Number:	CM15-0011472		
Date Assigned:	01/29/2015	Date of Injury:	10/25/2009
Decision Date:	03/25/2015	UR Denial Date:	01/14/2015
Priority:	Standard	Application Received:	01/21/2015

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: Physical Medicine & Rehabilitation

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 male patient, who sustained an industrial injury on 10/25/2009. A primary treating office visit dated 11/25/2014 reported subjective complaint of thoracic spine continued with persistent pain with any lengthy sitting. Physical examination found thoracic spine with tenderness, and spasm; range of motion; 46/20/22 degrees. Lumbar spine also tender with palpation and range of motion; 45/16/18/17 degrees. Lastly, cervical spine with decreased range of motion. The following diagnoses are applied; cervical spine strain/sprain, thoracic spines strain/sprain, and lumbar spine bilateral S 1, facet degenerative joint disease. The plan of care involved finishing sessions of acupuncture, return to modified work on 10/16/2014. On 01/14/2015 Utilization Review non-certified a request for 8 chiropractic sessions treating the cervical, thoracic and lumbar spine; along with interferential stimulation, noting the CA MTUS Chronic Pain, Opiod, and medical treatment was cited. The injured worker submitted an application for independent medical review of services requested.

IMR ISSUES, DECISIONS AND RATIONALES

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

Chiropractic treatment for the cervical, thoracic and lumbar spine, 2 times a week for 4 weeks; 8 sessions: Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Manual therapy and manipulation Page(s): 58.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Manual therapy & manipulation Page(s): 58-59.

Decision rationale: This patient presents with persistent low back pain. The current request is for CHIROPRACTIC TREATMENT FOR THE CERVICAL, THORACIC AND LUMBAR SPINE, 2 TIMES A WEEK FOR 4 WEEKS, 8 SESSIONS. For manual therapy, the MTUS guidelines on page 59 states, "Delphi recommendations in effect incorporate two trials, with a total of up to 12 trial visits with a re-evaluation in the middle, before also continuing up to 12 more visits (for a total of up to 24)." The Utilization review denied the request stating that there was insufficient documentation of measurable and functional improvement on examination to support continued use. The medical file includes only two progress reports dated 11/16/14 and 11/25/14. The treating physician states that the patient has had chiropractic treatment in the past which were beneficial. The patient has returned to work with modification. The number of completed treatment and time frame for which they were completed are not clear. Given that prior sessions were beneficial and the patient is currently working, the requested 8 sessions is supported by MTUS. This request IS medically necessary.

Interferential stimulation unit: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Interferential Current Stimulation (ICS) Page(s): (s) 118-120.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Interferential Current Stimulation (ICS) Page(s): 118-120.

Decision rationale: This patient presents with persistent low back pain. The current request is for INTERFERENTIAL STIMULATION UNIT. The Utilization review denied the request stating that there is no indication that the requested modality will be used in conjunction with skilled therapy. For Interferential Current Stimulation (ICS), the MTUS guidelines, pages 118 - 120, state that "Not recommended as an isolated intervention. There is no quality evidence of effectiveness except in conjunction with recommended treatments, including return to work, exercise and medications, and limited evidence of improvement on those recommended treatments alone." These devices are recommended in cases where (1) Pain is ineffectively controlled due to diminished effectiveness of medications; or (2) Pain is ineffectively controlled with medications due to side effects; or (3) History of substance abuse; or (4) Significant pain from postoperative conditions limits the ability to perform exercise programs/physical therapy treatment; or (5) Unresponsive to conservative measures (e.g., repositioning, heat/ice, etc.). In this case, there is no documentation of substance abuse, operative condition, or unresponsiveness to conservative measures. The requested interferential unit IS NOT medically necessary.