MAXIMUS Federal Services

Case Number:	CM15-0124935		
Date Assigned:	07/09/2015	Date of Injury:	08/14/2000
Decision Date:	08/05/2015	UR Denial Date:	06/09/2015
Priority:	Standard	Application Received:	06/29/2015

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: Massachusetts
Certification(s)/Specialty: Physical Medicine & Rehabilitation, Pain Management

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 53-year-old female who sustained an industrial injury on 8/14/00. She had complaints of low back pain. Chiropractic progress note dated 5/11/15 reports extreme back pain and severe sciatic pain in her right leg. The injured worker reported significant relief in pain after her last treatment on 4/13/15 she used ice, was able to sleep all night and was able to return to work the next day. She was doing well and performing usual activities until last week, the pain started again in her low back, hip, traveling down her right leg to her toe. Low back symptoms are constant, deep, burning, sharp, aching, muscle spasms and pain with movement. The symptoms radiate to her right hip, right thigh, right knee and right foot, rated 8/10. Diagnoses include: lumbar facet syndrome, lumbosacral myofascial pain, syndrome, sacroilitis, lower limb causalgia, thoracolumbar myofascial pain syndrome, lumbosacral joint sprain/strain, lumbosacral radiculopathy, thoracolumbar subluxation, sciatic neuritis, lumbar disk syndrome, lumbar radiculitis, and thoracic myofascial pain syndrome. Plan of care includes: chiropractic treatment to include examination, manipulation therapy, spinal adjusting, extremity adjusting, physiotherapy and modalities, massage therapy, electric stimulation and mechanical traction. Home therapy recommended: alternate cold and heat application on the pain areas for 20 minutes several times per day and perform daily exercises as demonstrated. Injured worker reports 80% pain relief after treatment today.

IMR ISSUES, DECISIONS AND RATIONALES

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

Chiro/PT 3 times per month x 3 months (9 visits): Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Manual therapy & manipulation, p58 Page(s): 58.

Decision rationale: The claimant has a remote history of a work-related injury and continues to be treated for hip and episodic back pain. When seen, she was being treated for a flare-up of back pain. She had done well after the last chiropractic treatment and had been able to return to work and provide care for her spouse. She was having pain when sitting at work with right lower extremity weakness and limping. There were muscle spasms with trigger points and restricted range of motion with fixations affecting the thoracic and lumbar spine and pelvis. Straight leg raising was positive bilaterally and all orthopedic tests performed were positive. She was unable to stand fully upright. The assessment references anticipated 1-2 treatments per flare-up and needing to unlock the lumbar facets at the lumbosacral junction as part of treatment. Chiropractic care is recommended as an option in the treatment of chronic pain. Guidelines recommend a trial of 6 visits over 2 weeks with further treatment considered if there is objective evidence of functional improvement and with a total of up to 18 visits over 6-8 weeks. In this case, the number of additional treatment sessions and duration of treatment being requested is in excess of the guideline recommendation. Prospectively requesting treatment is not appropriate. The request was not medically necessary.

TENS unit and supplies: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Transcutaneous electrotherapy, p114 Page(s): 114.

Decision rationale: The claimant has a remote history of a work-related injury and continues to be treated for hip and episodic back pain. When seen, she was being treated for a flare-up of back pain. She had done well after the last chiropractic treatment and had been able to return to work and provide care for her spouse. She was having pain when sitting at work with right lower extremity weakness and limping. There were muscle spasms with trigger points and restricted range of motion with fixations affecting the thoracic and lumbar spine and pelvis. Straight leg raising was positive bilaterally and all orthopedic tests performed were positive. She was unable to stand fully upright. The assessment references anticipated 1-2 treatments per flare-up and needing to unlock the lumbar facets at the lumbosacral junction as part of treatment. A one-month home-based trial of TENS may be considered as a noninvasive conservative option. Criteria for the continued use of TENS include documentation of a one-month trial period of the TENS unit including how often the unit was used, as well as outcomes in terms of pain relief. In this case, there is no documented home-based trial of TENS. Providing a TENS unit and supplies was not medically necessary.