

Case Number:	CM15-0030114		
Date Assigned:	02/23/2015	Date of Injury:	03/05/2014
Decision Date:	05/27/2015	UR Denial Date:	02/12/2015
Priority:	Standard	Application Received:	02/18/2015

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: New York

Certification(s)/Specialty: Internal Medicine

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 41-year-old female, who sustained an industrial injury on 3/5/2014. She reports pain in the back, shoulder and neck after lifting a heavy box. Diagnoses include lumbar intervertebral disc without myelopathy, cervical sprain/strain with disc protrusion, left shoulder sprain/strain with impingement syndrome, left elbow sprain/strain with lateral epicondylitis and lumbar sprain/strain with disc protrusion. Treatments to date include physical therapy and medication management. A progress report from the treating provider dated 1/10/2015 indicates the injured worker reported neck, left shoulder and left elbow pain and low back pain. On 2/12/2015, Utilization Review non-certified the request for 6 visits for chiropractic care for the lumbar spine, cold/heat therapy rental, 6 visits for lumbar spine LINT, lumbar brace and 6 visits for physical therapy, citing MTUS, ACOEM and Official Disability Guidelines.

IMR ISSUES, DECISIONS AND RATIONALES

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

Chiropractic treatment for lumbar spine, one time a week for six weeks (1 x 6): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Manual therapy & manipulation Page(s): 58-60.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Manual therapy & manipulation Page(s): 58. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back Chapter.

Decision rationale: MTUS recommends a trial of 6 Chiropractic visits over 2 weeks for initial therapeutic care. With evidence of objective functional improvement, a total of up to 18 visits over 6-8 weeks may be prescribed. Per MTUS, elective/maintenance care is not medically necessary. Documentation provided for review reveals that the injured worker has had previous chiropractic treatment, but there is lack of detailed information regarding the number of visits or objective clinical outcome of the treatment. Given that the injured worker has completed an initial course of chiropractic care and there is no report of significant improvement in physical function or exceptional factors, medical necessity for additional chiropractic treatment has not been established. Per guidelines, the request for Chiropractic treatment for lumbar spine, one time a week for six weeks (1 x 6) is not medically necessary.

Cold/heat therapy unit, 2 times a day for 15-20 mins, (rental): Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): Initial Care, pg 299. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back Chapter, Heat/Cold Packs.

Decision rationale: MTUS and ODG recommend at-home local applications of cold in the first few days of acute complaint of pain, followed thereafter by applications of heat or cold. Continuous low-level heat wrap therapy is superior to both acetaminophen and ibuprofen for treating low back pain. The evidence for the application of cold treatment to low-back pain is more limited than heat therapy. There is minimal evidence supporting the use of cold therapy, but heat therapy has been found to be helpful for pain reduction and return to normal function. MTUS provides no evidence recommending the routine use of high tech devices over the use of local cold or heat wraps. The request for Cold/heat therapy unit, 2 times a day for 15-20 mins, (rental) is not medically necessary by guidelines.

LINT for lumbar spine, one time a week for six weeks (1 x 6): Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Not addressed. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back Chapter, Hyperstimulation Analgesia.

Decision rationale: ODG states that Localized intense Neurostimulating therapy (LINT), a procedure, usually described as hyper stimulation analgesia, has been investigated in several controlled studies, but is not recommended until there are higher quality studies. Localized

manual high-intensity neurostimulation devices are used to apply localized, intense, low-rate electrical pulses to painful active myofascial trigger points. The request for LINT for lumbar spine, one time a week for six weeks (1 x 6) is not medically necessary due to lack of sufficient evidence to recommend its use as per ODG.

Lumbar brace, continuous daily use in a task specific manner: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): Initial Care, pg 301. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back Chapter, Lumbar supports.

Decision rationale: MTUS states that the use of Lumbar supports to treat low back pain has not been shown to have any lasting benefit beyond the acute phase of symptom relief. Per guidelines, lumbar supports may be recommended as an option for compression fractures and specific treatment of spondylolisthesis and documented instability. Long-term use of lumbar supports is not recommended. Chart documentation does not indicate any acute objective findings to justify the use of lumbar support to treat this injured worker's chronic complaints of back pain. The request for Lumbar brace, continuous daily use in a task specific manner is not medically necessary.

Physical therapy for lumbar spine, one time a week for six weeks (1 x 6): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Physical Therapy Guidelines.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Page(s): 98 & 99. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back Chapter.

Decision rationale: MTUS and ODG guidelines recommend 10 physical therapy visits over 8 weeks for medical management of Lumbar sprains and strains and intervertebral disc disorders without myelopathy. As time goes, one should see an increase in the active regimen of care or decrease in the passive regimen of care and a fading of treatment of frequency (from up to 3 or more visits per week to 1 or less). When the treatment duration and/or number of visits exceed the guidelines, exceptional factors should be noted. Documentation provided for review reveals that the injured worker has had previous physical therapy, but there is lack of detailed information regarding the number of visits or objective clinical outcome of the treatment. Given that the injured worker has completed an initial course of physical therapy and there is no report of significant improvement in physical function or exceptional factors, medical necessity for additional physical therapy has not been established. Per guidelines, the request for Physical therapy for lumbar spine, one time a week for six weeks (1 x 6) is not medically necessary.