

Case Number:	CM15-0092156		
Date Assigned:	05/18/2015	Date of Injury:	04/04/2000
Decision Date:	06/18/2015	UR Denial Date:	04/20/2015
Priority:	Standard	Application Received:	05/13/2015

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, Indiana, 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 68 year old male, who sustained an industrial injury on 04/04/2000. On provider visit dated 03/30/2015 the injured worker has reported bilateral lower back pain, numbness and numbness in bilateral legs and right knee pain. On examination the lumbar spine revealed a decreased range of motion and pain with same. Lumbar spine was also noted to have tenderness on palpation, Kemp's test positive. Right knee was noted to have no tenderness to palpation. And cold sensation was decreased on right lateral thigh. The diagnoses have included lumbar displacement of IVD and thoracalgia. Treatment to date has included chiropractic therapy and medication. Documentation submitted included a functional improvement assessment. The provider requested electronic muscle stimulation 2 x month x 6 months, myofascial release and Chiro CMT.

IMR ISSUES, DECISIONS AND RATIONALES

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

Chiro CMT: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Chiropractic therapy Page(s): 58-60. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low back section, Chiropractic therapy.

Decision rationale: Pursuant to the Chronic Pain Medical Treatment Guidelines and the Official Disability Guidelines, chiropractic (CMT) are not medically necessary. Manual manipulation and therapy is recommended for chronic pain is caused by musculoskeletal conditions. The intended goal or effective manual medicine is the achievement of positive symptomatic or objective measurable gains and functional improvement. Manipulation, therapeutic care-trial of 6 visits over two weeks. With evidence of objective functional improvement, total of up to 18 visits over 6 to 8 weeks. Elective/maintenance care is not medically necessary. In this case, the injured worker's working diagnoses are lumbar displacement of IVD; and thoracalgia. Subjectively, according to a March 30, 2015 progress note, the injured worker complains of bilateral low back pain 6/10. Objectively, there is decreased range of motion. The injured worker received prior manipulation therapy that helps for approximately 2 weeks with return of symptoms. There is no objective evidence of functional improvement in the medical record with prior chiropractic treatment. The injured worker is requesting additional chiropractic treatment two times per month time six months. There is no documentation of prior chiropractic treatment in the medical record. The treating provider states transient improvement with chiropractic treatment. Consequently, absent clinical documentation of objective functional improvement with an unspecified number of prior chiropractic treatment sessions to date (date of injury 15 years prior to April 4, 2000) in excess of the recommended guidelines, chiropractic (CMT) are not medically necessary.

Myofascial Release: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Massage therapy Page(s): 60.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Massage therapy Page(s): 60. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain section, Massage therapy.

Decision rationale: Pursuant to the Chronic Pain Medical Treatment Guidelines and the Official Disability Guidelines, myofascial release is not medically necessary. Massage is a passive intervention and considered an adjunct to other recommended treatment, especially active interventions (e.g. exercise). Massage therapy should be limited to 4-6 visits in most cases. See the guidelines for details. Massage therapy is beneficial in attenuating diffuse musculoskeletal symptoms, but beneficial effects were registered only during treatment. Massage is a passive intervention and treatment dependence should be avoided. In this case, the injured worker's working diagnoses are lumbar displacement of IVD; and thoracalgia. Subjectively, according to a March 30, 2015 progress note, the injured worker complains of bilateral low back pain 6/10. Objectively, there is decreased range of motion. The injured worker received prior manipulation therapy that helps for approximately 2 weeks with return of symptoms. There is no objective evidence of functional improvement in the medical record with prior chiropractic treatment. Massage therapy (myofascial release) should be limited to 4-6 visits in most cases. There is no prior documentation of massage therapy in the medical record. It is unclear whether the injured worker received prior massage therapy (myofascial release) therapy over the prior 15 years. The injured worker is requesting myofascial release two times

per week from six months. This request is in excess of the recommended guidelines where massage therapy should be limited to four - six visits. Consequently, absent compelling clinical documentation with evidence of objective functional improvement with prior myofascial release progress notes, myofascial release is not medically necessary.

EMS 2 x month x 6 months: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines TENS Page(s): 114 to 116. Decision based on Non-MTUS Citation Official Disability Guidelines TWC Pain Procedure Summary - Criteria for use of TENS.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines TENS Unit Page(s): 116. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain section, TENS Unit.

Decision rationale: Pursuant to the Chronic Pain Medical Treatment Guidelines and the Official Disability Guidelines, electro-muscle-stimulator (TENS) 2 times a month times 6 months is not medically necessary. Neuromuscular electrical stimulation (NMES devices) are not recommended. NMES is primarily used as part of a rehabilitation program following stroke and there is no evidence to support its use in chronic pain. TENS is not recommended as a primary treatment modality, but a one-month home-based trial may be considered as a noninvasive conservative option, if used as an adjunct to a program of evidence-based functional restoration, including reductions in medication use. The Official Disability Guidelines enumerate the criteria for the use of TENS. The criteria include, but are not limited to, a one month trial period of the TENS trial; there is evidence that appropriate pain modalities have been tried and failed; other ongoing pain treatment should be documented during the trial including medication usage; specific short and long-term goals should be submitted; etc. In this case, the injured worker's working diagnoses are lumbar displacement of IVD; and thoracalgia. Subjectively, according to a March 30, 2015 progress note, the injured worker complains of bilateral low back pain 6/10. Objectively, there is decreased range of motion. The injured worker received prior manipulation therapy that helps for approximately 2 weeks with return of symptoms. There is no objective evidence of functional improvement in the medical record with prior chiropractic treatment. There is no clinical documentation of a TENS trial in the medical record. There are no specific short and long-term goals referencing the TENS unit. Consequently, absent clinical documentation including a TENS trial with short and long-term goals, electro-muscle-stimulator (TENS) 2 times a month times 6 months is not medically necessary.