

Case Number:	CM13-0008467		
Date Assigned:	09/09/2013	Date of Injury:	02/28/2012
Decision Date:	03/26/2014	UR Denial Date:	07/09/2013
Priority:	Standard	Application Received:	08/08/2013

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Physical Medicine and Rehabilitation, has a subspecialty in Neuromuscular Medicine and is licensed to practice in Maryland. 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 physician 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:

Patient is a female with a date of birth [REDACTED] and a date of work injury 2/28/12. Her complaints per the 6/14/13 primary treating physician note include low back pain with numbness, tingling, pain, and weakness down both legs right worse than left. She also complained of persistent neck pain, right shoulder pain, right knee pain radiating down to the heel, and urinary incontinence. Her diagnoses include: cervical spine sprain/strain, right shoulder sprain/strain, left upper extremity radiculopathy, lumbar spine disc protrusions, lumbar spine radiculopathy, right knee internal derangement, myospasms, cervical spine multilevel disc bulges. There are requests for 12 chiropractic manipulative treatments, 1 initial QFCE, and 1 EMS TENS unit. The physical exam on the 6/14/13 primary treating physician office visit revealed that patient had a normal gait, appeared anxious and in no acute distress. She has tenderness to palpation of the left upper trapezius muscle and suboccipital area worse on the right. There is a positive Spurling's test (location not specified) and a negative compression and distraction test. The lumbar spine exam reveals has tenderness to palpation with spasms of the paraspinals and tenderness to palpation of the sacroiliacs. The range of motion of the lumbar spine is limited secondary to pain. The patient has decreased sensation to light touch of the right lateral thigh. There is a positive sitting root test. The upper extremity exam reveals tenderness to palpation of her right AC joint and tenderness to palpation with spasms of the right upper trapezius muscle. There is positive crepitus (with no additional details documented). She has tenderness to palpation of the right wrist joint. She has tenderness to palpation of the right greater trochanter. She has limited range of motion of the hip secondary to pain. She has tenderness to palpation of the right infrapatellar region and the left lateral knee. She also has tenderness to palpation of the right knee popliteal fossa. She has full range of motion with pain at end ranges. Positive McMurray's bilaterally and

crepitus. Sensation is intact of the bilateral lower extremities. There is documentation of a 10/03/2012 electrodiagnostic study of the lower extremities which revealed a normal study. There is also an 11/03/2012 MRI of the Cervical Spine with Flexion and Extension- which reveals disc desiccation, reversal of normal cervical lordosis. C3-C4 3.8-mm disc bulge. C4-C5, 2.9-mm disc bulge. C5-C6, 2.9-mm disc bulge. C6-C7, 2.9-mm disc bulge.

IMR ISSUES, DECISIONS AND RATIONALES

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

Twelve (12) retrospective chiropractic manipulative therapy treatments between 4/23/2012 and 8/20/2012: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 298-299.

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

Decision rationale: Twelve (12) retrospective chiropractic manipulative therapy treatments are not medically necessary per the MTUS guidelines. The MTUS guidelines recommend manual therapy and manipulation for low back pain with a Trial of 6 visits over 2 weeks, with evidence of objective functional improvement with total of up to 18 visits over 6-8 weeks. Patient started chiropractic therapy on 3/14/12 with no significant functional improvement or significant improvement in pain levels. Twelve (12) retrospective chiropractic manipulative treatments are not medically necessary

One (1) retrospective initial QFCE between 4/23/2012 and 8/20/2012: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Fitness For Duty.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 1 Prevention Page(s): 12.

Decision rationale: 1 initial QFCE is not medically necessary. The ACOEM states that at present, there is not good evidence that functional capacity evaluations are correlated with a lower frequency of health complaints or injuries. The ODG states that a functional capacity evaluation can be considered when case management is hampered by complex issues such as a prior unsuccessful return to work attempts, conflicting medical reporting, or injuries that require detailed exploration of a worker's abilities. The ODG also states that an FCE can be obtained if a patient is close to MMI or secondary conditions need to be clarified. The documentation submitted does not reveal complex cases management issues. The documentation does not indicate that the patient is close to MMI or if secondary conditions need to be clarified. The request for one (1) retrospective initial QFCE is not medically necessary or appropriate.

One (1) retrospective EMS TENS between 4/23/2012 and 8/20/2012: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 300.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Neuromuscular electrical stimulation (NMES devices), Functional Restoration Approach to Chronic.

Decision rationale: One (1) retrospective EMS TENS unit is not medically necessary. The MTUS does not recommend an EMS unit for chronic pain. The EMS unit is used for stroke patients, spinal cord injured patients or in some cases to stimulate the quadriceps muscles following major knee surgeries as part of a comprehensive physical therapy program. A TENS unit for chronic pain is recommended as an adjunct to a program of evidence-based functional restoration. The patient was given an EMS TENS unit per documentation without specified time/duration of use. There is no documentation of a program of a coordinated goal oriented functional restoration approach. Furthermore, a review of the submitted records indicates a normal bilateral lower extremity electrodiagnostic study in the past with no evidence of an immobilized extremity, spinal cord injury or stroke. . If one modality of a combination electrical stimulation unit is not recommended, then the entire unit is not recommended. Therefore, the request for one (1) retrospective TENS/EMS unit is not deemed medically necessary or appropriate.