

Case Number:	CM13-0026502		
Date Assigned:	11/22/2013	Date of Injury:	03/31/2013
Decision Date:	01/17/2014	UR Denial Date:	08/22/2013
Priority:	Standard	Application Received:	09/04/2013

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 Internal Medicine and Cardiology, has a subspecialty in Cardiovascular Disease and is licensed to practice in Texas. 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.

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 patient is a 42-year-old male who reported an injury on 03/22/1999. The mechanism of injury was noted to be carrying a heavy gun belt. The patient was noted to have physical therapy. The diagnoses were noted to include a lumbar spine sprain/strain and left hip spasms/strain. The request was made for physical therapy 2 times a week for 4 weeks for the low back and left hip, 1 home electrical muscle stimulation unit and 1 MRI of the left hip.

IMR ISSUES, DECISIONS AND RATIONALES

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

Physical therapy two (2) times a week for four (4) weeks for the low back and left hip:
Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): s 98-99.

Decision rationale: CA MTUS states that physical medicine with passive therapy can provide short term relief during the early phases of pain treatment and is directed at controlling symptoms such as pain, inflammation and swelling and to improve the rate of healing soft tissue injuries. Active therapy is based on the philosophy that therapeutic exercise and/or activity are beneficial for restoring flexibility, strength, endurance, function and range of motion and can

alleviate discomfort. Treatment is recommended with a maximum of 9-10 visits for myalgia and myositis. The documentation submitted for review indicated that the patient had an improvement in the functional ability to walk without a limp "with short strides", but full stride was noted to give symptoms to the left lower extremity. The patient noted improvement with stairs. The patient was noted to have low back pain and a positive straight leg raise. There was a lack of objective measurements the patient's functional improvement and a lack of documentation indicating the number of sessions that the patient had participated in. There was a lack of the patient's remaining functional deficits documentation to support the necessity for 8 additional sessions of physical therapy. Additionally, the patient should be well versed in a home exercise program. Given the above, the request for physical therapy 2 times a week for 4 weeks for the low back and left hip is not medically necessary.

One (1) home electrical muscle stimulator unit: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Knee & Leg, Neuromuscular electrical stimulation (NMES devices).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): s 97,120-121.

Decision rationale: The California MTUS Guidelines address different types of electrical muscle stimulators and they are addressed separately, specifically regarding the NMES, California MTUS does not recommend neuromuscular electrical stimulation devices except as part of a rehabilitation program following a stroke. Regarding PENS, a percutaneous electrical nerve stimulation unit is not recommended as a primary treatment modality and is recommended only after therapeutic exercise and TENS, have been tried and failed or are judged to be unsuitable or contraindicated and a TENS unit may be considered if used as an adjunct program and micro current electrical stimulation is not recommended. The clinical documentation submitted for review, while asking for an electrical muscle stimulator unit, failed to provide which type of unit is being requested. Given the above lack of clarification, the request for 1 home electrical muscle stimulator unit is not medically necessary.

One (1) MRI of the left hip: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM. Decision based on Non-MTUS Citation ODG, Low Back

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Hip & Pelvis Chapter, MRI, Online Version.

Decision rationale: The California MTUS/ACOEM Guidelines do not address an MRI of the hip. The Official Disability Guidelines recommend an MRI of the hip when the patient has acute and chronic soft tissue injuries. The clinical documentation submitted indicated the patient had a previous MRI on 05/06/2013 and the patient was noted to have a questionable right acetabular

fray, however, for review failed to document the rationale for a second MRI. Additionally, there was a lack of documentation that the patient had a significant change in his symptoms or objective examination findings to support the need for a second MRI. Given the above, the request for an MRI of the left hip is not medically necessary.