

Case Number:	CM13-0037236		
Date Assigned:	07/02/2014	Date of Injury:	07/23/2013
Decision Date:	07/31/2014	UR Denial Date:	09/18/2013
Priority:	Standard	Application Received:	09/19/2013

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. The expert reviewer is Board Certified in Physical Medicine and Rehabilitation and is licensed to practice in California. 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/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:

The injured worker is a 30-year-old female who reported an injury on 07/23/2013 due to a motor vehicle accident. On 09/03/2013, she reported low back pain and left hip pain. The physical examination of the lumbar spine revealed hypolordosis, tenderness to palpation over the bilateral paravertebral musculature and lumbosacral junction, spasm bilaterally, tenderness to palpation over the left sacroiliac joint, negative straight leg raise bilaterally, and Patrick/FABERE test is positive for increased left sided sacroiliac joint pain and left hip pain. Range of motion of the lumbar spine was shown to be flexion to 50 degrees, extension to 14 degrees, right sided bending to 17 degrees, and left sided bending to 15 degrees. Physical examination of the left hip revealed normal symmetry and contour. There was tenderness to palpation over the left sacroiliac joint and gluteus musculature primarily the medius, Patrick/FABERE test was positive for left sided sacroiliac joint and gluteal pain. Range of motion of the left hip showed to be flexion to 90 degrees, extension to 21 degrees, abduction to 28 degrees, adduction to 15 degrees, internal rotation to 31 degrees, and external rotation to 39 degrees. Her diagnoses included lumbar spine musculoligamentous sprain and strain with left sided sacroiliac joint pain and left hip strain. Past treatment therapies included physical therapy, ice, and medication along with modified duty. It was also noted that she had attended at least 2 chiropractic sessions. The treatment plan was for a home electrical muscle stimulation unit and physiotherapy/chiropractic services 3 x 4. The request for authorization was signed on 09/13/2013. The rationale for treatment was not provided.

IMR ISSUES, DECISIONS AND RATIONALES

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

HOME ELECTRICAL MUSCLE STIMULATION UNIT: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 300. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), TWC Low Back Procedure Summary.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Neuromuscular electrical stimulation, page(s) 121 Page(s): 121.

Decision rationale: The requesting physician stated that the use of the home electrical muscle stimulation unit was to help manage pain, reduce spasms, and reduce medication use. The California MTUS Guidelines state that neuromuscular electrical stimulation devices are not recommended. These devices are primarily used as part of a rehabilitation program following stroke and there is no evidence to support its use in chronic pain. Based on the clinical information provided, the injured worker did not suffer from a stroke. In addition, it was not noted within the physical exam performed on 09/03/2013 that the injured worker had spasms and/or was using medication for her pain. Furthermore, the request did not indicate the specific location for the home electrical muscle stimulation unit to be used on. The request is not supported by the Guideline recommendations. Therefore, the request is not medically necessary.

PHYSIOTHERAPY/CHIROPRACTIC SERVICES 3 X 4: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 298-299. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), TWC Low Back Procedure Summary.

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

Decision rationale: It was noted that the injured worker had attended at least 4 chiropractic therapy sessions; however, there was no documentation regarding objective functional improvement with the prior sessions. The California MTUS Guidelines state that manual therapy and manipulation is recommended for chronic pain is caused by musculoskeletal conditions. For the low back, a trial of 6 visits over 2 weeks is recommended with evidence of objective functional improvement a total of up to 18 visits can be recommended. If chiropractic treatment is going to be effective, there should be some outward sign of subjective or objective improvement within the first 6 visits. Treatment beyond 4 to 6 visits should be documented with objective improvement in function. The documentation provided is lacking information regarding objective functional improvement to determine efficacy of the prior sessions and warrant additional sessions. The request is not supported by Guideline recommendations. As such, the request for Physiotherapy/Chiropractic Services 3 X 4 is not medically necessary.