

Case Number:	CM14-0120576		
Date Assigned:	08/06/2014	Date of Injury:	02/22/2014
Decision Date:	09/11/2014	UR Denial Date:	07/14/2014
Priority:	Standard	Application Received:	07/30/2014

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 licensed in Chiropractic 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 patient is a 43-year-old female born on 08/18/1971. While working on 02/22/2014, she was standing on a chair to put up candles, and when she stepped down off the chair she fell and injured her right knee. The patient presented for chiropractic care on 06/25/2014 with complaints of right knee pain, right sacroiliac pain, and right calf pain. Lumbar spine examination revealed tenderness to palpation and muscle tension, hypertonicity, and spasm. The right sacroiliac joint, the thoracic spine, and the right knee were tender to palpation with noted muscle tension. Lumbar spine, right hip, and right knee ranges of motion were restricted with pain. Kemp's, Lasegue's, Braggard's and Patrick's Fabere were reported positive bilaterally. Lower extremity DTRs were 2+ bilaterally. She was diagnosed with medial collateral ligament sprain/strain, hip and thigh sprain/strain, and lumbosacral sprain/strain. Treatment consisted of chiropractic spinal manipulation in the thoracolumbar spine (98940) and electrical stimulation (97014) to the low back, right hip and right knee. The chiropractor recommended a treatment plan of 2 times per week for 4 weeks. The lower extremity functional scale of 06/25/2014 reports a total score of 77 and 96%. The Oswestry Assessment of 07/02/2014 reports 22 total points.

IMR ISSUES, DECISIONS AND RATIONALES

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

Retrospective Chiropractic Treatments/Electrical Stim times 4 for low back, right hip, right knee (dos 6/25, 6/30, 7/32, 7/7/14): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Manual therapy & Manipulation Page(s): 58-59.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Manual Therapy & Manipulation (pages 58-60); TENS, chronic pain (transcutaneous electrical nerve stimulation) (pages 114-117); Galvanic stimulation (page 117); H-wave stimulation (HWT) (pages 117,118); Interferential current stimulation (ICS) pages 118-120); Microcurrent electrical stimulation (MENS devices) (pages 120,121); Neuromuscular electrical stimulation (NMES devices) (page 121); and Sympathetic therapy (page 121) Page(s): 58-60-121.

Decision rationale: Treatment consisted of chiropractic spinal manipulation in the thoracolumbar spine (98940) and electrical stimulation (97014) to the low back, right hip and right knee. Medical necessity is supported for 4 visits of spinal manipulation treatments (98940) to the lower back on 06/25/2014, 06/30/2014, 07/02/2014 and 07/07/2014. Medical necessity is not supported for 4 visits of electrical stimulation (97014) to the low back, right hip and right knee on 06/25/2014, 06/30/2014, 07/02/2014 and 07/07/2014. MTUS (Medical Treatment Utilization Guidelines) supports a trial of up to 6 visits over 2 weeks of manual therapy and manipulation in the treatment of chronic low back pain complaints if caused by musculoskeletal conditions. The time to produce effect is 4-6 treatments. Treatment beyond 4-6 visits should be documented with objective improvement in function. With evidence of objective functional improvement with care during the 6-visit treatment trial, a total of up to 18 visits over 6-8 weeks may be considered. Elective/maintenance care is not medically necessary. Relative to recurrences/flare-ups, there is the need to evaluate prior treatment success, if RTW (return to work) then 1-2 visits every 4-6 months. Retrospective chiropractic spinal manipulation (98940) to the patient's lumbosacral region on 06/25/2014, 06/30/2014, 07/02/2014 and 07/07/2014 is supported by MTUS (Medical Treatment Utilization Guidelines) in order to determine if chiropractic care could establish objective functional improvement with care rendered during a 4-6 visit manipulative treatment trial. MTUS (Medical Treatment Utilization Guidelines) does not support medical necessity for electrical stimulation (97014) to the low back, right hip and right knee on 06/25/2014, 06/30/2014, 07/02/2014 and 07/07/2014. The chiropractic documentation does not report the specific type of electrical muscle stimulation performed, but MTUS does not support electrotherapies in this case. In this case MTUS does not support TENS because the patient does not meet the criteria necessary for use of TENS. MTUS reports the following electrical therapies are not recommended: galvanic stimulation, H-wave stimulation (HWT), interferential current stimulation (ICS), microcurrent electrical stimulation (MENS devices), neuromuscular electrical stimulation (NMES devices), and sympathetic therapy. Retrospective electrical stimulation (97014) to the low back, right hip and right knee on 06/25/2014, 06/30/2014, 07/02/2014 and 07/07/2014 is not supported by MTUS (Medical Treatment Utilization Guidelines).

Additional Chiropractic Treatment/Electrical Stim times 4 for low back, right hip, right knee: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Manual therapy & Manipulation Page(s): 58-59.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Manual Therapy & Manipulation (pages 58-60); TENS, chronic pain (transcutaneous electrical nerve stimulation) (pages 114-117); Galvanic stimulation (page 117); H-wave stimulation (HWT) (pages 117,118); Interferential current stimulation (ICS) pages 118-120); Microcurrent electrical stimulation (MENS devices) (pages 120,121); Neuromuscular electrical stimulation (NMES devices) (page 121); and Sympathetic therapy (page 121 Page(s): 58- 121.

Decision rationale: Additional chiropractic spinal manipulation in the thoracolumbar spine (98940) and electrical stimulation (97014) to the low back, right hip and right knee is not supported to be medically necessary. MTUS (Medical Treatment Utilization Guidelines) does not support medical necessity for additional chiropractic spinal manipulation (98940).MTUS (Medical Treatment Utilization Guidelines) supports a trial of up to 6 visits over 2 weeks of manual therapy and manipulation in the treatment of chronic low back pain complaints if caused by musculoskeletal conditions. The time to produce effect is 4-6 treatments. Treatment beyond 4-6 visits should be documented with objective improvement in function. With evidence of objective functional improvement with care during the 6-visit treatment trial, a total of up to 18 visits over 6-8 weeks may be considered. Elective/maintenance care is not medically necessary. Relative to recurrences/flare-ups, there is the need to evaluate prior treatment success, if RTW (return to work) then 1-2 visits every 4-6 months. Treatment beyond 4-6 visits should be documented with objective improvement in function. There is no documentation of measured objective functional improvement with the 4 visits of chiropractic spinal manipulative care rendered from 06/25/2014 through 07/07/2014; therefore, additional spinal manipulation visits are not supported.MTUS (Medical Treatment Utilization Guidelines) does not support medical necessity for additional electrical stimulation (97014) to the low back, right hip and right knee. MTUS (Medical Treatment Utilization Guidelines) do not support medical necessity for electrical stimulation (97014) to the low back, right hip and right knee on 06/25/2014, 06/30/2014, 07/02/2014 and 07/07/2014. The chiropractic documentation does not report the specific type of electrical muscle stimulation performed, but MTUS does not support electrotherapies in this case. In this case MTUS does not support TENS because the patient does not meet the criteria necessary for use of TENS. MTUS reports the following electrical therapies are not recommended: galvanic stimulation, H-wave stimulation (HWT), interferential current stimulation (ICS), microcurrent electrical stimulation (MENS devices), neuromuscular electrical stimulation (NMES devices), and sympathetic therapy.