

Case Number:	CM14-0054476		
Date Assigned:	07/07/2014	Date of Injury:	02/06/2013
Decision Date:	08/14/2014	UR Denial Date:	04/16/2014
Priority:	Standard	Application Received:	04/24/2014

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 Board Certified in Anesthesiology, has a subspecialty in Pain Medicine 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 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 43 year old female who reported an injury to her thoracic spine and lumbar spine on 2/6/13. No information was submitted regarding initial injury. The injured worker had significant past medical history involving fall from a swing as a child in 1997 and subsequent motor vehicle accident. Clinical note dated 02/20/14 indicated the injured worker having additional complaints of pain at the ankles as a result of the motor vehicle accident. The injured worker was also reported to have undergone a having sustained injuries related to domestic violence episode where she her back was beaten resulting the injured worker was also sustained a torn retina. Clinical note dated 03/21/14 indicated the injured worker complaining of low back pain and achiness in both knees. Utilization review dated 04/15/14 resulted in denial for use of OrthoStim device and ongoing chiropractic therapy. The injured worker had been approved for a trial of six chiropractic manipulation visits. The use of the OrthoStim device was supported after a failure of additional methods of conservative treatment. No information was submitted regarding previous failure of conservative treatment.

IMR ISSUES, DECISIONS AND RATIONALES

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

Orthostim 4; one (1) month rental; additional three (3) months rental if effective: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Transcutaneous Electrotherapy. Decision based on Non-MTUS Citation Official Disability Guidelines: Neuromuscular electrical stimulation (NMES devices); Galvanic Stimulation.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Interferential Current Stimulation (ICS) Page(s): 118-9.

Decision rationale: The clinical documentation indicates the injured worker complaining of pain at several sites most notably low back the mid and low back and knees and ankles. No information was submitted regarding previous trials of additional therapies with resultant failure. Additionally, while the OrthoStim device is indicated for a one month rental, the additional request for three month rental would be indicated provided clinical documentation is in place confirming an objective functional improvement following the initial trial. Without this information in place this request is not indicated as medically necessary.

Chiropractic treatment; twelve (12) visits (three (3) times per week for four (4) weeks):
Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Manual therapy & manipulation.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Manual therapy & manipulation Page(s): 58.

Decision rationale: According to the clinical notes the injured worker has been approved for a trial of six chiropractic manipulation visits. Additional chiropractic therapy would be indicated provided that the injured worker meets specific criteria, including objective functional improvement through the initial course of treatment. No objective data was submitted regarding the patient's response to previously rendered chiropractic therapy. Given this, the request is not indicated as medically necessary.