

Case Number:	CM13-0043619		
Date Assigned:	01/15/2014	Date of Injury:	08/10/2012
Decision Date:	03/25/2014	UR Denial Date:	10/14/2013
Priority:	Standard	Application Received:	10/14/2013

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 Occupational Medicine 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 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:

The patient is a 60 year old male who re-injured on 08/10/2012 to his back while working. Treatment history included 6 weeks of aquatic therapy, medications and epidurals up to 4-6 times. 05/02/2001, MRI of the lumbar spine showed overall reduction diameter of the thecal sac was reduced which may be due to the epidural lipomatosis. Multilevel disk bulging might be seen in the lumbar spine with measurement. Maximum encroachment into the right neural foramen raising the possibility of irritation in the right L5 nerve root. 05/02/2001, EMG lower extremities showed there was normal EMG of the bilateral lower extremities without any findings of active denervation of bilateral lumbosacral myotomes bilaterally. 05/02/2001, Nerve Conduction Study showed there is normal NCS of the peripheral nerve of the bilateral lower extremities without findings of mononeuropathy, peripheral neuropathy or plexopathy. MRI lumbar spine w/o contrast dated 12/10/2012 showed straightening of the normal lumbar lordosis; moderate multi level degenerative changes of the lumbar spine including broad based disc bulges and mild hypertrophic facet arthropathy; L5-S1 moderate bilateral neural foraminal narrowing; L4-L5 mild-moderate right neural foraminal narrowing and L3-L4 mild left neural foraminal narrowing. 4/9/2013, EMG/NCV of lower extremities showed no evidence of radiculopathy. A clinical note dated 10/18/2013 indicated decrease pain and spasticity in all four extremity, increased range of motion, increased strength in all four extremity, flexion 50%, extension 0%, Right SB 50%, and Left SB 40%. Treatment included therapeutic exercise, stretching program, core strengthening, PRF balance, e-stim, MHP and lumbar traction.

IMR ISSUES, DECISIONS AND RATIONALES

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

OrthoStim/Interferential Stimulator Rental (Purchase x2 Month) & Supplies: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Interferential Current Stimulation (ICS) Page(s): 118-119;308.

Decision rationale: Per MTUS guidelines, "Interferential stimulator is not recommended as an isolated intervention. There is no quality evidence of effectiveness except in conjunction with recommended treatments, including return to work, exercise and medications, and limited evidence of improvement on those recommended treatments alone. The randomized trials that have evaluated the effectiveness of this treatment have included studies for back pain, jaw pain, soft tissue shoulder pain, cervical neck pain and postoperative knee pain." The provider states that the patient experienced prior benefit with OrthoStim use in conjunction with physical therapy but no specifics are given in terms of functional improvement, pain reduction, or evidence of medication reduction. There appears to have been no lasting benefit given the patient's worsening pain complaints and persistent poor functioning. Also, the request for orthoStim/Interferential Stimulator Rental (Purchase x2 Month) & Supplies exceeds the guidelines recommendation. Therefore, the request is non-certified.

Acupuncture (x18): Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS Acupuncture Treatment Guidelines.

Decision rationale: As per CA MTUS guidelines: "time to produce functional improvement: 3 to 6 treatments." The provider is requesting acupuncture treatment x18; Approval of 6 treatments is recommended. Further treatment authorization should be dependent upon derived functional benefit or pain reduction. Therefore acupuncture x18 is non-certified.

MRI Lumbar Spine - Repeat: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303-305.

Decision rationale: As per CA MTUS guidelines, MRI is recommended for unequivocal objective findings that identify specific nerve compromise on examination. The patient has had 5/5 lower extremity strength, positive SLR bilaterally, reduced reflexes bilaterally, and decreased sensation of the R foot prior to a lumbar MRI done in December 2012. EMG/NCS done 4/9/13

showed no radiculopathy and mild peripheral neuropathy consistent with diabetes. While the patient's pain complaints have reportedly increased recently, his physical examination findings have not progressed according to the records. Medical necessity has not been established. Lumbar MRI is non-certified.