

Case Number:	CM13-0050614		
Date Assigned:	12/27/2013	Date of Injury:	01/16/2012
Decision Date:	03/12/2014	UR Denial Date:	10/11/2013
Priority:	Standard	Application Received:	11/14/2013

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 Internal Medicine and is licensed to practice in New York. 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 claimant is a 39-year-old female who sustained a work related injury on 01/16/2012. She slipped on oil on the floor and injured her low back. Her diagnoses include lumbar radiculopathy, myofascial pain, and pain related insomnia. She complains of neck bilateral shoulders and low back pain. On exam she has tenderness and decreased range of motion of the neck and lumbar spine with radiation of pain to both lower extremities. She has been treated with medical therapy, physical therapy, injection therapy, and chiropractic. The treating provider has requested additional physical therapy sessions, an IF (interferential) unit with one month's supplies, an Internal Medicine consultation, and one session of FCE functional capacity evaluations) physical therapy.

IMR ISSUES, DECISIONS AND RATIONALES

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

Physical Therapy treatment 2 times a week for 4 weeks: Upheld

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

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

Decision rationale: Chronic Pain Medical Treatment Guidelines 2009, physical therapy is indicated for the treatment of neck, shoulder and low back pain. Recommendations state that for most patients with more severe acute and subacute low back pain conditions 8 to 12 visits over a period of over 6 to 8 weeks is indicated as long as functional improvement and program progression are documented. Active therapy is based on the philosophy that therapeutic exercise and/or activity are beneficial for restoring flexibility, strength, endurance, function, range of motion, and can alleviate discomfort. Patients are instructed and expected to continue active therapies at home as an extension of the treatment process in order to maintain improvement levels. Home exercise can include exercise with or without mechanical assistance or resistance and functional activities with assistive devices. In this case the claimant has completed prior physical therapy sessions without a reported good benefit. There is no specific indication for additional sessions. Medical necessity for the requested additional physical therapy sessions has not been established. The requested service is not medically necessary.

IF (Interferential) Unit with 1 month supplies: Upheld

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

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

Decision rationale: The requested Interferential current stimulation is not medically necessary . It 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. While not recommended as an isolated intervention, patient selection criteria if Interferential stimulation is to be used anyway: possibly appropriate for the following conditions if it has documented and proven to be effective as directed or applied by the physician or a provider licensed to provide physical medicine:- Pain is ineffectively controlled due to diminished effectiveness of medications; or- pain is ineffectively controlled with medications due to side effects; or history of substance abuse; or significant pain from postoperative conditions limits the ability to perform exercise programs/physical therapy treatment; or- unresponsive to conservative measures (e.g., repositioning, heat/ice, etc.). Medical necessity for the requested treatment has not been established. Therefore the requested treatment is not medically necessary.

Internal Medicine Consult: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Page(s): 127.

MAXIMUS guideline: Decision based on MTUS ACOEM Page(s): 127.

Decision rationale: There is no specific indication outlined for an Internal Medicine consultation. Per Occupational Medicine Practice Guidelines, a health practitioner may refer to other specialists if a diagnosis is uncertain or extremely complex when the plan or course of care

may benefit from additional expertise. Medical necessity for the requested service has not been established. Therefore the requested service is not medically necessary.

1 session of FCE (Functional Capacity Evaluations) Physical Therapy: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ACOEM 2nd Edition, Chapter 7 Independent Medical Examinations and Consultations (pp 132-139).

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

Decision rationale: Chronic Pain Medical Treatment Guidelines 2009, physical therapy is indicated for the treatment of neck, shoulder and low back pain. Recommendations state that for most patients with more severe acute and subacute low back pain conditions 8 to 12 visits over a period of over 6 to 8 weeks is indicated as long as functional improvement and program progression are documented. Active therapy is based on the philosophy that therapeutic exercise and/or activity are beneficial for restoring flexibility, strength, endurance, function, range of motion, and can alleviate discomfort. Patients are instructed and expected to continue active therapies at home as an extension of the treatment process in order to maintain improvement levels. Home exercise can include exercise with or without mechanical assistance or resistance and functional activities with assistive devices. In this case the claimant has completed prior physical therapy sessions without a reported good benefit. There is no specific indication for additional sessions. Medical necessity for the requested additional physical therapy session has not been established. The requested service is not medically necessary.