

Case Number:	CM13-0064214		
Date Assigned:	01/03/2014	Date of Injury:	04/01/2012
Decision Date:	04/15/2014	UR Denial Date:	11/19/2013
Priority:	Standard	Application Received:	12/11/2013

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 Orthopedic Surgery 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 claimant is a 51-year-old female who was injured in a work related accident on April 1, 2012. The clinical records provided for review included a December 10, 2013 handwritten progress report documenting diagnoses of bilateral plantar fasciitis, lumbar intervertebral disc disorder, and lumbar strain. Subjectively, there were complaints of pain in the lumbar spine with diminished range of motion and weakness. Objectively, there was noted to be pain on palpation of the foot bilaterally with limited lumbar range of motion and no documented neurologic findings. Recommendation was made for six sessions of physical therapy, the use of a back brace, aqua therapy times six weeks and a multi-stim unit with supplies for further treatment. A previous lumbar MRI dated October 30, 2013 showed multilevel disc bulging with grade I anterolisthesis at L4-5 with moderate bilateral foraminal narrowing. The report of an MRI scan of the left foot dated October 30, 2013 showed artifact, but no evidence of fracture, soft tissue mass, or joint effusion.

IMR ISSUES, DECISIONS AND RATIONALES

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

SIX SESSIONS OF PHYSICAL THERAPY: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 474.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Page(s): 98-99.

Decision rationale: Based on the MTUS Chronic Pain Medical Treatment Guidelines, the request for physical therapy at this chronic stage in the claimant's course of care would not be indicated. The records provided for review do not indicate why the claimant would be unable to transition to an aggressive home exercise program given clinical findings that do not demonstrate motor weakness or functional deficit. The request for six sessions of physical therapy is not medically necessary and appropriate.

ASPEN BACK BRACE: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG)

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 9 298,301.

Decision rationale: Based on the ACOEM Guidelines, the request for a back brace for the claimant's current working diagnosis would not be indicated. Back braces are not recommended except in cases of postsurgical settings, significant segmental instability or fracture. The claimant does not meet any of the above diagnoses based on recent imaging and current clinical picture. The role of a back brace at this stage of chronic course of care would not be indicated. The request for an Aspen back brace is not medically necessary and appropriate.

AQUA THERAPY WATER CIRCULATING PAD/BACK WRAP: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 22.

Decision rationale: Based on MTUS Chronic Pain Medical Treatment Guidelines, aquatic therapy is not indicated, thus negating the need for this aqua therapy associated device. The request for aqua therapy water circulating pad/back wrap is not medically necessary and appropriate.

AQUA THERAPY: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Aquatic Therapy Page(s): 22.

Decision rationale: Based on the California MTUS Chronic Pain Medical Treatment Guidelines, the request for aquatic therapy times six weeks would not be indicated. Chronic Pain Guidelines would only recommend the role of isolated physical therapy in the chronic setting. The specific request for six weeks of therapy from an aquatic point of view in this individual who gives no documentation of an inability to perform land based home exercises would not be necessary. The request for six sessions of aqua therapy is not medically necessary and appropriate.

ADAPTOR: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not cite any medical evidence for its decision.

Decision rationale: Since the primary treatment is not medically necessary, none of the associated services are medically necessary.

2 LEAD WIRES: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not cite any medical evidence for its decision.

Decision rationale: Since the primary treatment is not medically necessary, none of the associated services are medically necessary.

ELECTRODES 8 PAIR PER MONTH, 5 MONTH RENTAL:

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

MAXIMUS guideline: The Expert Reviewer did not cite any medical evidence for its decision.

Decision rationale: Since the primary treatment is not medically necessary, none of the associated services are medically necessary.

1 SOLACE MULTI STIM UNIT, 5 MONTH RENTAL: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not cite any medical evidence for its decision.

Decision rationale: Based on the MTUS Chronic Pain Medical Treatment Guidelines, the request for a "Solace multi-stim unit" would not be indicated. In general, multi-stim units contain both interferential stimulation as well as neuromuscular electrical stimulation. Neuromuscular electrical stimulation is not supported in the chronic pain setting and is reserved for treatment in the setting of post stroke or paresis treatment. The role of the Solace multi-stim device at this stage of the claimant's chronic course of care, particularly for a five month rental, would not be supported. The request for Solace multi-stim unit for five month rental is not medically necessary and appropriate.