

Case Number:	CM14-0003017		
Date Assigned:	01/29/2014	Date of Injury:	06/01/2009
Decision Date:	12/18/2014	UR Denial Date:	12/30/2013
Priority:	Standard	Application Received:	01/08/2014

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 Emergency 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 52-year-old female who reported an injury on 06/01/2009. The injury reportedly occurred when the injured worker was hit in the arm by falling boxes. Her diagnoses included degeneration of the lumbosacral intervertebral disc, right elbow lateral epicondylitis, right hip greater trochanteric bursitis, and right lower extremity atrophy. Her past treatments have included medications, physical therapy, and a right hip injection. A clinical note indicated that a magnetic resonance imaging of the lumbar spine on 06/19/2010 showed findings of lumbar disc protrusion of 4 mm centrally with right lower extremity radiculopathy with right neural foraminal stenosis at L5-S1. Her surgical history was not provided. A progress report dated 11/07/2013 noted the injured worker had low back pain radiating down to the right leg with weakness. Upon physical examination, she was noted to have tenderness over the right hip greater trochanteric area and a limp. Examination of the lower extremities revealed significant weakness and calf atrophy of the right lower extremity. Examination of the lumbar spine indicated tenderness, pain, and a positive straight leg raise. Her current medication regimen was not provided. The treatment plan included referrals for pain management, psychiatric evaluation and treatment, implementation of approved physical therapy with monitoring for the following 6 weeks, a 6 week followup visit, and the request for a lumbar support brace. The rationale for the request was for gait training and quadriceps strengthening. A Request for Authorization form was not provided.

IMR ISSUES, DECISIONS AND RATIONALES

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

PHYSICAL THERAPY (2X6) FOR THE LUMBAR SPINE AND RIGHT LOWER EXTREMITY: Upheld

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

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

Decision rationale: The request for physical therapy 2x6 for the lumbar spine and right lower extremity is not medically necessary. The injured worker has chronic low back pain radiating to the right lower extremity. The California MTUS Guidelines recommend physical medicine. 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. The guidelines recommend up to 10 visits for unspecified radiculitis. The clinical note dated 11/07/2013 indicated that the injured worker had received authorization for physical therapy and would be getting started on those sessions. The clinical documentation submitted failed to include quantifiable objective deficits, such as decreased range of motion or decreased motor strength, in the lumbar spine or right lower extremity. Additionally, the number of completed physical therapy sessions and whether there was objective functional improvement is unknown. Additionally, the requested number of visits exceeds the recommended guidelines. As such, the request for physical therapy 2x6 for the lumbar spine and right lower extremity is not medically necessary.

MUSCLE STIMULATOR: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Neuromuscular electrical stimulation (NMES devices) Page(s): 121.

Decision rationale: The request for a muscle stimulator is not medically necessary. The injured worker had chronic low back pain radiating to her right lower extremity. The California MTUS Guidelines state neuromuscular electrical stimulation is used primarily as part of a rehabilitation program following stroke and there is no evidence to support its use in chronic pain. The documentation submitted for review did not indicate the injured worker recently had a stroke. As such, the request for muscle stimulator is not medically necessary.