

Case Number:	CM14-0106876		
Date Assigned:	07/30/2014	Date of Injury:	07/24/1996
Decision Date:	10/14/2014	UR Denial Date:	06/11/2014
Priority:	Standard	Application Received:	07/10/2014

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 and Pain Medicine and is licensed to practice in Florida. 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 68 year-old female who reported an injury on 07/24/1996. The mechanism of injury was not provided. Diagnoses included lumbar strain/sciatica, bilateral rotator cuff tear, and right knee arthritis. Past treatment included pain medication. Diagnostic studies included an unofficial MRI of the lumbar spine which revealed a 4 mm protrusion at L4-5; however, the official report and the date of the MRI were not provided. The injured worker was seen by the primary care physician on 07/28/2014 and complained of low back pain radiating to the bilateral lower extremities. The physician did not include a documented physical examination. The injured worker was prescribed lidoderm patches and Ultram for pain management. The treatment plan was for an MRI of the lumbar spine and continuation of pain medication. The rationale for the request was not provided. The request for authorization form was signed on 05/12/2014.

IMR ISSUES, DECISIONS AND RATIONALES

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

MRI of the Lumbar Spine: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303-305. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back, MRI's.

Decision rationale: The request for an MRI of the lumbar spine is not medically necessary. The injured worker has a history of low back pain radiating to the bilateral lower extremities. The California MTUS/ACOEM guidelines state unequivocal objective findings that identify specific nerve compromise on the neurologic examination are sufficient evidence to warrant imaging in patients who do not respond to treatment and who would consider surgery an option. The Official Disability Guidelines further state repeat MRI is not routinely recommended, and should be reserved for a significant change in symptoms and/or findings suggestive of significant pathology (eg, tumor, infection, fracture, neurocompression, recurrent disc herniation). There was no documentation of serious symptoms or progressive neurological findings that would require an MRI. There is a lack of documentation demonstrating the injured worker has findings indicative of neurologic deficit upon physical examination including a positive straight leg raise, decreased sensation, decreased strength, and decreased deep tendon reflexes. There is no indication that the injured worker has experienced a significant change in symptoms or findings indicative of significant pathology. Thus, the request for MRI of the Lumbar Spine is not medically necessary.

MRI of the Sacrum/Coccyx: 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: The request for an MRI of the sacrum/coccyx is not medically necessary. The injured worker has a history of low back pain radiating to the bilateral lower extremities. The California MTUS/ACOEM Guidelines state unequivocal objective findings that identify specific nerve compromise on the neurologic examination are sufficient evidence to warrant imaging in patients who do not respond to treatment and who would consider surgery an option. The Official Disability Guidelines further state repeat MRI is not routinely recommended, and should be reserved for a significant change in symptoms and/or findings suggestive of significant pathology. There was no documentation of serious symptoms or progressive neurological findings that would require an MRI. There is a lack of documentation demonstrating the injured worker has findings indicative of neurologic deficit upon physical examination including a positive straight leg raise, decreased sensation, decreased strength, and decreased deep tendon reflexes. There is no indication that the injured worker has experienced a significant change in symptoms or findings indicative of significant pathology. Therefore, in the absence of a clear indication for the request and a specific rationale from the provider, the necessity of MRI of the Sacrum/Coccyx cannot be established. Thus, the request for MRI of the Sacrum/Coccyx is not medically necessary.

Unknown Supplies for OrthoStim Unit: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Transcutaneous electrotherapy Page(s): 114-118.

Decision rationale: The request for unknown supplies for orthostim unit is not medically necessary. The injured worker has a history of low back pain radiating to the bilateral lower extremities. The California MTUS guidelines state that interferential current stimulation 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. Furthermore, the California MTUS state microcurrent stimulation is not recommended. Based on the available evidence, conclusions cannot be made concerning the effect of Microcurrent Stimulation Devices (MENS) on pain management. Given that orthostim is a combination of two therapies that are not recommended per the guideline for the treatment of low back pain, the request is not warranted. Also, the request for unspecified supplies would require clarification and re-submission. As such, the request for Unknown Supplies for OrthoStim Unit is not medically necessary.