MAXIMUS Federal Services

Case Number:	CM14-0115619		
Date Assigned:	08/04/2014	Date of Injury:	11/17/2011
Decision Date:	10/01/2014	UR Denial Date:	06/30/2014
Priority:	Standard	Application Received:	07/23/2014

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 Physical Medicine & Rehabilitation, 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 injured worker is a 25-year-old female who reported an injury on 11/27/2011. She reportedly sustained injuries to her back from very heavy work. Treatment history included MRI studies, EMG studies, x-rays, and medications. Within the documentation submitted, the injured worker had an MRI that was normal. The injured worker was evaluated on 07/11/2014, and it was documented the injured worker underwent conservative care such as medications, physical and manipulating therapy, and injections to the lower back, and still had significant residual symptoms. X-rays and/or MRI scans and/or CT scans and/or bone scans were performed. The injured worker was recommended to undergo extracorporeal shockwave treatment by the treating provider. The injured worker was evaluated on 07/07/2014, and it was documented the injured worker was referred for psychological evaluation on 06/11/2014. It was documented that a psychologist stated the injured worker developed symptoms of mental disorders including depression, anxiety, irritability, and insomnia. Other significant symptoms included crying episodes, damaged self-esteem, fatigue, and trouble concentrating. It was documented it was not possible to estimate, psychological basis or return to work date for regular or modified work, as well as it cannot yet be determined on a psychological base where the injured worker would eventually be emotionally able to engage in occupations she performed at this time of injury. The Request for Authorization dated 04/16/2014 was for a pain management consultation.

IMR ISSUES, DECISIONS AND RATIONALES

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

Shockwave therapy to T/S and L/S 1 x12: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ACOEM Guidelines 2007 page 166-173

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low back & Thoracic, Shock Wave Therapy.

Decision rationale: The request for Shockwave therapy to T/S and L/S 1 x12 is not medically necessary. Per the Official Disability Guidelines (ODG) do not recommend shock wave therapy. The available evidence does not support the effectiveness of ultrasound or shock wave for treating LBP. In the absence of such evidence, the clinical use of these forms of treatment is not justified and should be discouraged. As such, the request is not medically necessary.

IF Unit: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines Back Garments and ACOEM Guidelines 2007 166-173

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines INTERFERENTIAL CURRENT STIMULATION Page(s): 118.

Decision rationale: The California MTUS Guidelines do not recommend interferential current stimulation as an isolated intervention. The clinical documentation submitted for review failed to indicate the injured worker would be utilizing the interferential current stimulator as an adjunct to other therapies. The request as submitted failed to indicate whether the request was for rental or purchase and the duration of use was not established. Given the above, the request for IF Unit is not medically necessary.

L/S localized Intense Neruostimulation Therapy: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ACOEM Guidelines 2007 page 166-173

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

Decision rationale: The requested L/S localized Intense Neurostimulation Therapy is not medically necessary. Per California Medical Treatment Utilization Schedule Guidelines state NMES is not recommended. NMES is used primarily as part of a rehabilitation program following stroke and there is no evidence to support its use in chronic pain. There are no intervention trials suggesting benefit from NMES for chronic pain. The scientific evidence related to electromyography (EMG) triggered electrical stimulation therapy continues to evolve, and this therapy appears to be useful in a supervised physical therapy setting to rehabilitate atrophied upper extremity muscles following stroke and as part of a comprehensive PT program.

Neuromuscular electrical stimulation devices NMES, through multiple channels attempts to stimulate motor nerves and alternately causes contraction and relaxation of muscles, unlike a TENS device which is intended to alter the perception of pain. NMES devices are used to prevent or retard disuse atrophy, relax muscle spasm, increase blood circulation, maintain or increase range of motion, and re-educate muscles. The documents submitted indicated the injured worker has had prior physical therapy; however, the outcome measurements were not submitted for review. The request failed to indicate location where therapy is required. As such, the request for L/S localized Intense Neurostimulation Therapy is not medically necessary.

Pain Management Consultation: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Page(s): 8-14, 127.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain (Chronic), Office Visits.

Decision rationale: The request for Pain Management Consultation is not medically necessary. Per the Official Disability Guidelines (ODG), office visits are recommended based on patient concerns, signs and symptoms, clinical stability, and reasonable physician judgment. The documents submitted indicated the injured worker failed conservative care; however, there was lack of outcome measurements listed, such as physical therapy measures and home exercise regimen. In addition, the documents failed to indicate longevity of medication usage for the injured worker. There is a lack of documentation of long term goals regarding functional improvement. Given the above, the request for pain management referral consultation is not medically necessary.