

Case Number:	CM14-0022353		
Date Assigned:	02/26/2014	Date of Injury:	09/21/2013
Decision Date:	03/10/2015	UR Denial Date:	02/12/2014
Priority:	Standard	Application Received:	02/22/2014

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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:

State(s) of Licensure: Maryland

Certification(s)/Specialty: Physical Medicine & Rehabilitation, Neuromuscular Medicine

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 patient is a female who had a work injury dated 0/21/13. The diagnoses include lumbar musculoligamentous sprain/strain with left lower extremity radiculitis; thoracic musculoligamentous sprain/strain. Per documentation there was a 10/7/13 progress note that states that the patient comes with low back pain, mid back pain and stomach upset. On physical exam there was a scoliotic curvature in the thoracic spine and dextroscoliosis in the lumbar spine. There was tenderness over the paraspinal muscles and lumbosacral junction. The straight leg raise caused increased low back pain bilaterally. There was decreased range of motion. There was spasm and muscle guarding over the thoracic spine with decreased range of motion. The lower extremity revealed decreased L4, L5 sensation to light touch and pin prick. There is a request for PT to the thoracic and lumbar spine and an Orthostim 4 for pain management. Per documentation on 11/21/13 the patient complained of upper and low back pain, stiffness and muscle spasm. She had moderate pain and at times it was severe. She had 4 visits of PT with no adverse effect. She was unable to return to work due to pain levels increased with work activities causing upper and low back pain. There was decreased dorsolumbar active range of motion and pain over the lumbar parspinals. Per documentation a 1/3/14 progress note states that the patient completed 6 sessions of PT and reports increased pain and spasms. She had low back pain radiating to the left foot with numbness/tingling. There was tenderness over the lumbar paraspinals and decreased range of motion. A 3/11/14 appeal states that the ODG guideline emphasize that the number of PT visits is not absolute for every case. Additionally the 8 sessions is still within allowable number of treatments since an employee is entitled to no more than 24

visits per year of PT. The appeal stats that a one month trial is not a compelling rule in the MTUS and that the unit will be an adjunct to PT and home exercise.

IMR ISSUES, DECISIONS AND RATIONALES

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

Physical Therapy 2x4: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints, Chronic Pain Treatment Guidelines.

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

Decision rationale: Physical therapy 2 x 4 is not medically necessary per the MTUS Chronic Pain Medical Treatment Guidelines. The guidelines recommend up to 10 visits for this condition. The documentation indicates that the patient has had prior therapy for this condition. There is no objective therapy documentation indicating evidence of functional improvement. There is no rationale indicated on why the patient cannot perform a home exercise program. Without evidence of exactly how many therapy sessions she has had and the outcome additional therapy cannot be certified.

OrthoStim4: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 116.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Galvanic Stimulation & Interferential Current Stimulation (ICS) & Neuromuscular electrical stimu.

Decision rationale: Orthostim 4 Unit is not medically necessary per the MTUS guidelines. OrthoStim unit utilize TENS, interferential current, galvanic and NMES. The MTUS Chronic Pain Medical Treatment Guidelines state that galvanic stimulation is considered investigational for all conditions. The MTUS Chronic Pain Medical Treatment Guidelines notes that NMES is not supported for the treatment of chronic pain and used primarily for post stroke rehabilitation. Additionally, the Chronic Pain Medical Treatment Guidelines note that interferential current stimulation (ICS) is not recommended as an isolated intervention. The unit includes galvanic stimulation and NMES which are clearly not recommended per the MTUS guidelines. The patient has not had any documentation of stroke. There are no indications for an Orthostim Unit for this patient. Therefore, the request for Orthostim 4 Unit is not medically necessary.