

Case Number:	CM15-0002479		
Date Assigned:	01/13/2015	Date of Injury:	08/30/2013
Decision Date:	03/16/2015	UR Denial Date:	12/29/2014
Priority:	Standard	Application Received:	01/06/2015

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: California, New York, Florida

Certification(s)/Specialty: Internal Medicine, Pulmonary Disease, Critical Care 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 injured worker is a 37-year-old male who reported an injury on 08/20/2013. The mechanism of injury was the injured worker was on top of a ladder opening boxes when he slipped and fell approximately 8 feet. The injured worker was noted to suffer a heel fracture of the right foot and was given a boot. The surgical history was stated to be no relevant surgeries. The medications included Hydrocodone, Tramadol, Omeprazole and Meloxicam. The documentation of 12/10/2014 revealed the injured worker was having low back pain and had participated in 12 sessions of physical therapy. The physical examination revealed +2 spasm and tenderness to the bilateral lumbar paraspinal muscles from L1-4 and the multifidus. The injured worker had decreased range of motion and had a positive Kemp's test bilaterally. The Yeoman's test was positive bilaterally. The reflexes were +2. The myotomes and dermatomes were within normal limits. The physical examination of the ankle and foot revealed +3 spasm and tenderness to the right anterior heel, right lateral malleolus, and plantar fascia. Range of motion was painful. The varus testing was positive on the right. There were no diagnostic studies noted. The treatment plan included acupuncture, myofascial release, electrical stimulation, infrared therapy, diathermy, a multi-interferential stimulator for 1 month trial, and a functional capacity evaluation. There was no Request for Authorization submitted for review.

IMR ISSUES, DECISIONS AND RATIONALES

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

Myofascial Release: Upheld

Claims Administrator guideline: Decision based on MTUS Acupuncture Treatment Guidelines.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Massage therapy Page(s): 60.

Decision rationale: The California Medical Treatment Utilization Schedule Guidelines recommend massage therapy that is limited to 4 to 6 visits. The clinical documentation submitted for review indicated the request was for myofascial release. However, the body part to be treated and the quantity of sessions was not provided per the request. Given the above, the request for myofascial release is not medically necessary.

E-stim infrared: Upheld

Claims Administrator guideline: Decision based on MTUS Acupuncture Treatment Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines-TWC and BlueCross BlueShield: TENS

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines TENS unit Page(s): 114-116. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back Chapter, Infrared.

Decision rationale: The California Medical Treatment Utilization Schedule Guidelines indicate the use of a TENS unit is appropriate as an adjunct to ongoing treatment modalities within a functional restoration approach and there is evidence that other pain modalities have been trialed and failed, including medications. They do not, however, address infrared therapy. As such, secondary guidelines were sought. The Official Disability Guidelines indicate that infrared therapy is not recommended over other therapies. It may be considered for a limited trial if for treatment of acute low back pain, but only if used as an adjunct to a program of evidence based conservative care including exercise. There was a lack of documentation indicating the E stim unit that was being requested. There was a lack of documented duration of care being requested and whether the unit was for rental or purchase. The body part to be treated was not provided per the request. Given the above, the request for E-stim infrared is not medically necessary.

Diathermy: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines-TWC, Ankle & Foot Procedure Summary

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 Chapter, Diathermy

Decision rationale: The Official Disability Guidelines indicate that diathermy is not recommended as there is no proven efficacy in the treatment of low back symptoms. There was a lack of documentation of exceptional factors to warrant monitoring to guideline recommendations. Additionally, the request as submitted failed to indicate the frequency and the body part to be treated, as well as the duration. Given the above, the request for diathermy is not medically necessary.