

Case Number:	CM15-0014508		
Date Assigned:	02/02/2015	Date of Injury:	05/26/2014
Decision Date:	04/01/2015	UR Denial Date:	01/19/2015
Priority:	Standard	Application Received:	01/26/2015

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

Certification(s)/Specialty: Physical Medicine & Rehabilitation

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 31-year-old male who reported an injury on 05/26/2014. The mechanism of injury involved a fall. The current diagnosis is lumbar sprain/strain. The latest physician progress report submitted for review is documented on 08/08/2014. The injured worker presented with complaints of mild to moderately severe low back pain. The current medication regimen includes BioFreeze, cyclobenzaprine 5 mg, meloxicam 7.5 mg, and tramadol/acetaminophen 37.5/325 mg. Upon examination, there was restricted lumbar range of motion with intact sensation. Recommendations at that time included chiropractic therapy, acupuncture, and an MRI of the lumbar spine. There was no Request for Authorization Form submitted for review.

IMR ISSUES, DECISIONS AND RATIONALES

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

Extracorporeal Shock-Wave Therapy (ECSWT) of thoracic spine: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines Low back-Lumbar & Thoracic (Acute & Chronic) Shock wave therapy.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 298-300.

Decision rationale: The California MTUS/ACOEM Practice Guidelines state physical modalities such as massage, diathermy, cutaneous laser treatment, ultrasound, TENS therapy, PENS therapy, and biofeedback have no proven efficacy in treated acute low back symptoms. There are no guideline recommendations for extracorporeal shockwave therapy to the thoracic spine. There was no recent physician progress report submitted for review. There was no specific quantity listed in the request. Given the above, the request is not medically appropriate.

Physical Performance-FCE: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Page(s): Chapter 7 Independent Medical Examinations and Consultations, pages 132-139.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 5 Cornerstones of Disability Prevention and Management Page(s): 89-92. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Fitness for Duty Chapter, Functional Capacity Evaluation.

Decision rationale: California MTUS/ACOEM Practice Guidelines state a number of functional assessment tools are available including Functional Capacity Examination when reassessing function and functional recovery. The Official Disability Guidelines recommend a Functional Capacity Evaluation when the timing is appropriate and if case management has been hampered by complex issues. According to the documentation provided, the injured worker presented with ongoing complaints of low back pain. The injured worker was pending an MRI of the lumbar spine, as well as a course of chiropractic therapy and acupuncture. There was no indication that this injured worker has reached or is close to reaching Maximum Medical Improvement. There was also no documentation of any previous unsuccessful return to work attempts. Given the above, the request is not medically appropriate.

Lumbosacral Brace: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 298-300.

Decision rationale: The California MTUS/ACOEM Practice Guidelines state lumbar supports have not been shown to have any lasting benefit beyond the acute phase of symptom relief. There was no documentation of a significant functional limitation upon examination. The medical necessity for the requested durable medical equipment has not been established. Given the above, the request is not medically appropriate.

Physical Therapy Evaluation and Treatment Thoracic Spine, Lumbar Spine 2 Times A Week For 6 Weeks: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 99.

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

Decision rationale: The California MTUS Guidelines state 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. Treatment for unspecified myalgia and myositis includes 9 to 10 visits over 8 weeks. The current request for 12 sessions of physical therapy would exceed guideline recommendations. There was also no documentation of a significant musculoskeletal or neurological deficit upon examination. Given the above, the request is not medically appropriate.

Interferential Unit: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 120.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 117-121.

Decision rationale: 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. There should be documentation that pain is ineffectively controlled due to the diminished effectiveness of medications or side effects, a history of substance abuse or significant pain from postoperative conditions. There was no documentation of a failure of conservative treatment to include active rehabilitation and TENS therapy. There is also no documentation of a successful 1 month trial prior to the request for a unit purchase. Given the above, the request is not medically appropriate.

Hot and Cold Unit: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 298-300.

Decision rationale: The California MTUS/ACOEM Practice Guidelines state at home local applications of heat or cold are as effective as those performed by a therapist. There was no mention of a contraindication to at home local applications of heat and cold packs as opposed to a motorized mechanical device. There was also no documentation of a significant functional limitation upon examination. Given the above, the request is not medically appropriate.