

Case Number:	CM15-0165180		
Date Assigned:	09/02/2015	Date of Injury:	04/29/2013
Decision Date:	10/06/2015	UR Denial Date:	07/13/2015
Priority:	Standard	Application Received:	08/21/2015

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: Massachusetts

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

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 48 year old male who sustained an industrial injury on 4-29-2013. He was climbing down a truck cabin when he fell down backwards landing on his back and right leg. He has reported injury to the cervical spine, thoracic spine, lumbar spine, right hip, right knee, and right ankle and foot and has been diagnosed with lumbar disc displacement without myelopathy, cervical disc herniation without myelopathy, thoracic sprain strain, right hip sprain strain, bursitis of the right knee, and plantar fasciitis. Treatment has included home exercises, medical imaging, chiropractic care, and physical therapy. There was +1 spasm and tenderness to the bilateral paraspinal muscles from C2 to C7 and bilateral suboccipital muscles. Shoulder depression test was positive bilaterally. There was a trigger point to the bilateral paraspinal muscles from T1-T8. There was +2 spasm and tenderness to the bilateral lumbar paraspinal muscles from L1-S1 and multifidus. Kemp's test was positive bilaterally. The straight leg raise test was positive on the right. Yeoman's was positive bilaterally. There was +2 spasm and tenderness to the right gluteus medius muscle and right tensor fasciae latae muscle. Fabere's test was positive on the right. Anvil test was positive on the right. There was + 1 spasm and tenderness to the right anterior joint line. There was +3 spasm and tenderness to the plantar fascia. The treatment plan included a work hardening program. The treatment request included a work hardening program and electrical stimulation and infrared to the lumbar spine.

IMR ISSUES, DECISIONS AND RATIONALES

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

Work hardening program, 10 visits over 8 weeks: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Work conditioning, work hardening. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Physical Medicine Guidelines - Work Conditioning.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Work conditioning, work hardening, p125 Page(s): 125.

Decision rationale: The claimant sustained a work-related injury in April 2013 and is being treated for pain throughout the spine and right hip, knee, and ankle and foot. The claimant works as a trucker. When seen, there were cervical and lumbar muscle spasms. There were thoracic paraspinal muscle trigger points. There was hip, knee, and ankle and foot tenderness with muscle spasms. Shoulder depression, Kemp's and Yeoman tests were positive. There was right knee medial joint line tenderness. There were positive Fabere and Anvil tests. He had completed 18 physical medicine treatments consisting of acupuncture and reached a plateau. Authorization for work hardening was requested. Criteria for a Work Conditioning Program include completion of an adequate trial of physical or occupational therapy with improvement followed by plateau, defined return to work goal, and the worker must be no more than 2 years past date of injury. In this case, recent treatment includes acupuncture and an adequate trial of physical or occupational therapy is not documented. The requested sessions of work hardening are not medically necessary.

Electrical stimulation and infrared to lumbar (unspecified frequency and duration):
Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Interferential Current Stimulation (ICS).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Transcutaneous electrotherapy, p114 Page(s): 114. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back-Lumbar & Thoracic (Acute & Chronic), Infrared therapy (IR).

Decision rationale: The claimant sustained a work-related injury in April 2013 and is being treated for pain throughout the spine and right hip, knee, and ankle and foot. The claimant works as a trucker. When seen, there were cervical and lumbar muscle spasms. There were thoracic paraspinal muscle trigger points. There was hip, knee, and ankle and foot tenderness with muscle spasms. Shoulder depression, Kemp's and Yeoman tests were positive. There was right knee medial joint line tenderness. There were positive Fabere and Anvil tests. He had completed 18 physical medicine treatments consisting of acupuncture and reached a plateau. Authorization for work hardening was requested. Infrared therapy is not recommended over other heat therapies, although providers may consider a limited trial of IR therapy for treatment of acute low back pain if used as an adjunct to a program of evidence-based conservative care including exercise.

In this case, the claimant has chronic low back pain and the duration of treatment is not specified. There is other available heat modalities would be expected to be effective for his condition. The requested IR treatment is not medically necessary. In terms of electrical stimulation, the type of stimulation as well as frequency and duration of treatments is not specified and this request also cannot be accepted as being medically necessary.