

Case Number:	CM15-0186800		
Date Assigned:	10/05/2015	Date of Injury:	02/07/1997
Decision Date:	11/18/2015	UR Denial Date:	09/14/2015
Priority:	Standard	Application Received:	09/22/2015

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, Hawaii

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 58 year old female injured worker suffered an industrial injury on 2-7-1997. The diagnoses included lumbar strain-sprain with degenerative changes including disc bulges and spondylolisthesis and right lower extremity radiculopathy. On 6-22-2015 the treating provider reported pain decrease in the lumbar spine from 7 out of 10 to 4 to 5 out of 10. The pain in the leg was decreased. On exam there was stiffness and spasms that were moderate to moderate severe with reduced range of motion. Prior treatment included right and left lumbar nerve blocks 7-20-2015, chiropractic therapy (unknown number of sessions) and Norco. Request for Authorization date was 6-22-2015. The Utilization Review on 9-14-2015 determined non-certification for 6 EMS (electrical muscle stimulation) 2 times a week for 6 weeks and Ultrasound for the lumbar spine (low back).

IMR ISSUES, DECISIONS AND RATIONALES

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

6 EMS (electrical muscle stimulation) 2 times a week for 6 weeks: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Electrical stimulators (E-stim).

Decision rationale: The patient presents with pain affecting the low back and right lower extremity. The current request is for EMS (electrical muscle stimulation) 2 times a week for 6 weeks. The requesting treating physician report was not found in the medical reports provided for review. The report dated 2/18/15 (34B) states, "The patient will receive physical modalities", Heat (97010) and EMS (G0283)", to the lumbar spine 2 time(s) per week for 3 weeks." The MTUS Guidelines states that neuromuscular electrical stimulation (NMES) devices are 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 interventional trials suggesting benefit from NMES for chronic pain or postsurgical care. In this case, there is no documentation that suggests the patient has had a stroke recently and NMES is not recommended for the treatment of chronic pain as outlined by the MTUS guidelines. Furthermore, the patient has received NMES therapy previously and there is no documentation of functional improvement provided. The current request is not medically necessary.

Ultrasound for the lumbar spine (low back): Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

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, Ultrasound.

Decision rationale: The patient presents with pain affecting the low back and right lower extremity. The current request is for Ultrasound for the lumbar spine (low back). The requesting treating physician report was not found in the medical reports provided for review. The MTUS guidelines do not address the current request. The ODG guidelines state the following regarding diagnostic ultrasound for the low back: "Not recommended for the diagnosis of low back conditions. In uncomplicated low back pain its use would be experimental at best." The guidelines go on to state the following regarding therapeutic ultrasound for the low back: "Not recommended based on the medical evidence, which shows that there is no proven efficacy in the treatment of acute low back symptoms." In this case, ultrasound for the low back is not recommended by the ODG guidelines as outlined in the "Low Back" chapter. Additionally, there is no specification of frequency or duration, which is not allowed by the IMR process. The current request is not medically necessary.