MAXIMUS Federal Services

Case Number:	CM15-0186988		
Date Assigned:	09/29/2015	Date of Injury:	11/18/2014
Decision Date:	12/01/2015	UR Denial Date:	09/17/2015
Priority:	Standard	Application Received:	09/23/2015

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: New York
Certification(s)/Specialty: Internal 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 55 year old male who sustained an industrial injury on 11-18-2014. A review of medical records indicates the injured worker is being treated for degenerative disc disease of the lumbar spine, status post lumbar decompression, appearing to be a microdiscectomy, and neck pain. Medical records dated 6-17-2015 noted back pain that goes up towards his neck. He feels that the pain is worsened with activity and improves with rest. Pain was rated a 10 out 10 and tended to be constant. Physical examination of the cervical spine showed decreased range of motion. Shoulder motion was unrestricted in all planes. Lumbar range of motion was restricted. Treatment has included physical therapy and tramadol. Utilization review form dated 9-17-2015 noncertified cane, IF unit, NCV-EMG bilateral lower extremities, and a home exercise kit.

IMR ISSUES, DECISIONS AND RATIONALES

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

Cane: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Knee and Leg Chapter (updated 07/10/2015).

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Knee & Leg Chapter-- Walking aids (canes, crutches, braces, orthoses, & walkers).

Decision rationale: The California MTUS Guidelines are silent regarding the use of canes. According to the Official Disability Guidelines (ODG), "disability, pain, and age-related impairments seem to determine the need for a walking aid. Nonuse is associated with less need, negative outcome, and negative evaluation of the walking aid. Contralateral cane placement is the most efficacious for persons with knee osteoarthritis." In fact, no cane use may be preferable to ipsilateral cane usage as the latter resulted in the highest knee moments of force, a situation which may exacerbate pain and deformity. After review of the received medical records, there are no documented subjective or objective findings that would support the need for a walking aid. Therefore, based on the Guidelines and the submitted records, the request for a cane is not medically necessary.

Interferential stimulation (IF) unit, one month trial: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Electrical stimulators (E-stim). Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Chapter- Knee & Leg (Acute & Chronic) - Interferential current therapy (IFC).

Decision rationale: Per the CA MTUS guidelines, Interferential Current Stimulation (ICS) 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, and limited evidence of improvement on those recommended treatments alone. The randomized trials that have evaluated the effectiveness of this treatment have included studies for back pain, jaw pain, soft tissue shoulder pain, cervical neck pain and post-operative knee pain. The findings from these trials were either negative or non-interpretable for recommendation due to poor study design and/or methodologic issues. In addition although proposed for treatment in general for soft tissue injury or for enhancing wound or fracture healing, there is insufficient literature to support Interferential current stimulation for treatment of these conditions. There are no standardized protocols for the use of interferential therapy; and the therapy may vary according to the frequency of stimulation, the pulse duration, treatment time, and electrode-placement technique. As per Official Disability Guidelines (ODG), Interferential current therapy (IFC) is under study for osteoarthritis and recovery post knee surgery. Not recommended for chronic pain or low back problems. After knee surgery, home interferential current therapy (IFC) may help reduce pain, pain medication taken, and swelling while increasing range of motion, resulting in quicker return to activities of daily living and athletic activities. A review of medical records indicates the injured worker is being treated for degenerative disc disease of the lumbar spine, status post lumbar decompression, and neck pain. The treating provider's notes do not provide clear information about the failure of current

conservative treatment measures. Based on the currently available information in the submitted Medical Records of this injured worker, and per review of the guidelines, the medical necessity for Interferential Current Stimulation (ICS) unit has not been established. The requested Treatment: Interferential stimulation (IF) unit, one-month trial is not medically necessary.

NCV/EMG bilateral lower extremities: Upheld

Claims Administrator guideline: Decision based on MTUS Low Back Complaints 2004.

MAXIMUS guideline: Decision based on MTUS Low Back Complaints 2004, Section(s): Special Studies. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain Chapter-- Electrodiagnostic testing (EMG/NCS).

Decision rationale: The California MTUS/ACOEM Guidelines state, "Electromyography (EMG), including H-reflex tests, may be useful to identify subtle, focal neurologic dysfunction in patients with low back symptoms lasting more than three or four weeks." The ODG regarding nerve conduction studies (NCS) states, "Not recommended. There is minimal justification for performing nerve conduction studies when a patient is presumed to have symptoms on the basis of radiculopathy. EMGs (electromyography) are recommended as an option (needle, not surface) to obtain unequivocal evidence of radiculopathy, after 1-month conservative therapy, but EMG's are not necessary if radiculopathy is already clinically obvious." The injured worker is being treated for low back pain. The objective findings on examination did not include evidence of neurologic dysfunction such as sensory, reflex, or motor system change. There were no symptoms or findings that define evidence of a peripheral neuropathy. There was insufficient information provided by the attending health care provider to establish the medical necessity or rationale for the requested electrodiagnostic studies. The request for an EMG/NCV of the bilateral lower extremities is not medically necessary.

Home exercise kit: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Exercise. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Knee and Leg Chapter-Exercise equipment-Durable medical equipment (DME).

Decision rationale: As per MTUS, Exercise is recommended. There is strong evidence that exercise programs, including aerobic conditioning and strengthening, are superior to treatment programs that do not include exercise. There is no sufficient evidence to support the recommendation of any particular exercise regimen over any other exercise regimen. A therapeutic exercise program should be initiated at the start of any treatment or rehabilitation program, unless exercise is contraindicated. Such programs should emphasize education, independence, and the importance of an on-going exercise regime. As per ODG, durable medical equipment (DME) is recommended generally if there is a medical need and if the device or system meets Medicare's definition of durable medical equipment (DME), which is

defined as equipment that can withstand repeated use, can be rented and used by successive patients, and is primarily and customarily used to serve medical purpose. As per review of Medical Records, the injured worker has previously been in physical therapy, and therefore should be independent with a home exercise program. There is no information in the Medical Records how the use of a home exercise kit will help in improving the functional status of the injured worker. The requested treatment: Home exercise kit is not medically necessary.