MAXIMUS Federal Services

Case Number:	CM15-0050410		
Date Assigned:	03/23/2015	Date of Injury:	01/31/2011
Decision Date:	05/11/2015	UR Denial Date:	02/10/2015
Priority:	Standard	Application Received:	03/17/2015

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 66-year-old male who reported an injury on 01/31/2011. The mechanism of injury was cumulative trauma. Prior therapies included physical therapy, decompression therapy, TENS unit, epidural steroid injection, and facet injection. The diagnostic studies included an MRI of the lumbar spine on 04/22/2011, MRI of the right knee, and neurodiagnostics of the bilateral lower extremities. The documentation of 06/15/2011 revealed the injured worker had complaints of pain in the low back and right knee and the injured worker had locking and giving way of the right knee with walking and standing greater than 10 to 15 minutes. The injured worker had difficulty sleeping. The documentation indicated physical therapy 2 times a week provided partial relief. The examination of the lumbar spine revealed a positive straight leg raise into the bilateral calf muscles in an L5-S1 dermatomal pattern. The injured worker had positive spasms. The examination of the right knee revealed a positive Murray's, decreased range of motion, and guarding, as well as a tender MJC greater than LJL patella. The diagnoses included lumbar spine status post sprain and strain with bilateral lower extremity radiculopathy, right knee sprain and strain rule out internal derangement, grade 1 PHMM per MRI 04/22/2011. The treatment plan included an ortho spine consultation for lumbar spine, ortho consultation for right knee to discuss invasive treatment options, request TENS unit and moist heating pad to help decrease pain and increase range of motion, activities of daily living and functional capacity, continue physical therapy 2x6, acupuncture 1x6, referral to pain management physician for medication program consultation, and await Functional Capacity Evaluation consult results. The subsequent documentation of 08/03/2011 revealed the injured

worker had continuing low back pain. The injured worker had pain that increased with bending and lifting. The physical examination revealed the injured worker had a positive straight leg raise into the bilateral calf muscles, positive spasms, and tenderness at the SST, SA, and AC joint. The right knee revealed a positive Murray's examination with decreased range of motion. The diagnoses remained the same. The treatment plan included continuation of physical therapy and acupuncture, refer for medicine consult and spinal decompression 12 sessions for the treatment of discopathy and pain. There was a Request for Authorization submitted for review for the decompression therapy dated 08/03/2011 and there was a prescription for the TENS unit and moist heat dated 06/15/2011.

IMR ISSUES, DECISIONS AND RATIONALES

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

Retrospective request for 5 visits of spinal decompression therapy completed at Advanced Care between 08/3/2011 and 09/30/2011: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 300. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low back - Lumbar & Thoracic (Acute & Chronic).

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, IDD therapy (intervertebral disc decompression).

Decision rationale: The Official Disability Guidelines do not recommend spinal decompression therapy. The request was made for 12 sessions, however, there was a lack of documentation of exceptional factors to warrant non-adherence to guideline recommendations. Given the above, the request for retrospective request for 5 visits of spinal decompression therapy completed at Advanced Care between 08/3/2011 and 09/30/2011 is not medically necessary.

Retrospective request for 1 sleep study completed by Hitech Diagnostics betweem 09/14/2011 and 10/28/2011: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain (Chronic).

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain Chapter, Polysomnography.

Decision rationale: The Official Disability Guidelines indicate that polysomnography is recommended after at least 6 months of insomnia at least 4 nights a week that is unresponsive to behavior intervention and sedative sleep promoting medications and after psychiatric etiology has been excluded. The clinical documentation submitted for review failed to provide a documented rationale for the request. There was a lack of documentation indicating at least 6

months of insomnia, an unresponsiveness to behavioral interventions and sedative and sleep medications, and there was a lack of documentation indicating psychiatric etiology had been excluded. There was no physician documentation specifically requesting the intervention. Given the above, the request for retrospective request for 1 sleep study completed by Hitech Diagnostics between 09/14/2011 and 10/28/2011 is not medically necessary.

Retrospective request for 1 TENS unit with moist heating pad between 06/15/2011 and 09/04/2012: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Criteria for the use of TENS, chronic pain (transcutaneous electrical nerve stimulation).

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 298,Chronic Pain Treatment Guidelines TENS unit Page(s): 114-116.

Decision rationale: The California Medical Treatment Utilization Schedule recommends a one month trial of a TENS unit as an adjunct to a program of evidence-based functional restoration for chronic neuropathic pain. Prior to the trial there must be documentation of at least three months of pain and evidence that other appropriate pain modalities have been tried (including medication) and have failed. The clinical documentation submitted for review failed to provide evidence that other appropriate pain modalities had been tried and failed, including medications. The duration of use was not provided. Additionally, the American College of Occupational and Environmental Medicine Guidelines indicate that at home local applications of cold in the first few days of an acute complaint are appropriate and thereafter, application of heat and cold. There was a lack of documentation indicating a necessity for a moist heating pad. There was a lack of documentation indicating the injured worker could not utilize a heat pack at home. The request as submitted failed to indicate whether the unit was for rental or purchase. Given the above, the request for retrospective request for 1 TENS unit with moist heating pad between 06/15/2011 and 09/04/2012 is not medically necessary.

Retrospective request for 10 physical therapy visits completed between 06/15/2011 and 07/21/2011: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical medicine guidelines.

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

Decision rationale: The California Medical Treatment Utilization Schedule Guidelines recommend physical medicine treatment for myalgia, myositis, and radiculitis for up to 10 visits. The clinical documentation submitted for review indicated the injured worker had previously undergone physical medicine treatment. There was a lack of documentation indicating the quantity of sessions and the objective functional response that was noted from prior therapy. There was a lack of documentation indicating objective functional deficits that remained. Additionally, the request as submitted failed to indicate the body part to be treated. Given the

above, the request for retrospective request for 10 physical therapy visits completed between 06/15/2011 and 07/21/2011 is not medically necessary.

Retrospective request for 1 video fluoroscopic evaluation between 04/19/2011 and 04/26/2011: Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303-305.

Decision rationale: The American College of Occupational and Environmental Medicine indicates that unequivocal objective findings that identify specific nerve compromise on the neurologic examination are sufficient evidence to warrant imaging in injured workers who do not respond to treatment and who would consider surgery an option. The clinical documentation submitted for review indicated the injured worker had undergone an MRI of the lumbar spine on 04/22/2011. There was a lack of documentation indicating a necessity for a video fluoroscopic evaluation and if the requested procedure, was the actual MRI. The request as submitted failed to indicate the body part to be surveyed. There was a lack of documented rationale. Given the above, the request for retrospective request for 1 video fluoroscopic evaluation between 04/19/2011 and 04/26/2011 is not medically necessary.