

Case Number:	CM14-0116630		
Date Assigned:	08/04/2014	Date of Injury:	09/29/2012
Decision Date:	10/07/2014	UR Denial Date:	07/03/2014
Priority:	Standard	Application Received:	07/25/2014

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. The expert reviewer is Board Certified in Physical Medicine and Rehabilitation and is licensed to practice in California. 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

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 patient is a 22-year-old male who has submitted a claim for thoracic spine pain, thoracic spine degenerative disc disease, thoracic spine HNP/bulge, lumbar spine pain, lumbar spine degenerative disc disease, and lumbar spine HNP/bulge associated with an industrial injury date of September 29, 2012. Medical records from 2014 were reviewed. The patient complained of low back pain, rated 4/4 in severity. Physical examination showed tenderness from L5-S1 into the gluteal area. Range of motion was reduced on the lumbar spine. There was positive figure of 4 and supine straight leg raise test. There was slight diminished sensation at L4-L5 and L5-S1. Motor strength was intact. MRI of the lumbar spine, dated October 2012, revealed 6mm disc protrusion at L4-L5 on the right side compressing on the nerve root at L4-L5 and L5-S1. Official report of the imaging study was not available. Treatment to date has included medications, physical therapy, chiropractic treatment, TENS unit, home exercise program, activity modification, and lumbar epidural steroid injections. Utilization review, dated July 3, 2014, denied the request for IF (interferential) unit x 3 month rental for the lumbar because the records did not specify a response to conservative measures, and diminished effectiveness of medications, intolerance to medications, or history of substance abuse; denied the request for aqua therapy 2x6 for the lumbar because contraindication to land-based therapy, need for reduced weight bearing, and response to previous conservative therapy was not specified in the records; and denied the request for MRI of the lumbar spine because the patient does not have any progressive neurological deficits and response to prior conservative treatment was not specified.

IMR ISSUES, DECISIONS AND RATIONALES

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

Interferential unit x3 month rental for the lumbar: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Transcutaneous electrotherapy, Interferential Current Stimulation (ICS) Page(s): 118-120.

Decision rationale: Page 118-120 of CA MTUS Chronic Pain Medical Treatment Guidelines state that a one-month trial of the IF unit may be appropriate when pain is ineffectively controlled due to diminished effectiveness of medications, when pain is ineffectively controlled with medications due to side effects, in patients with a history of substance abuse, in the presence of significant pain from postoperative conditions limiting the ability to perform exercise programs/physical therapy treatment, or if the condition is unresponsive to conservative measures. In this case, the rationale for its use was not provided. There is no documentation regarding failure of pain medications or inability to perform physical therapy. There was no documented history of substance abuse, a postoperative status and unresponsiveness to conservative measures. There is also no documentation of a prior one-month trial of use of interferential unit to support further treatment. Therefore, the request for Interferential unit x3 month rental for the lumbar is not medically necessary.

Aqua therapy 2x6 for the lumbar: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 22.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Aquatic therapy Page(s): 22.

Decision rationale: As stated on pages 22 of the California MTUS Chronic Pain Medical Treatment Guidelines, aquatic therapy is recommended as an alternative to land-based physical therapy where reduced weight bearing is desirable such as extreme obesity. In this case, the rationale for the present request was not provided. The patient previously underwent several land-based therapy. However, a comprehensive and detailed documentation of the overall progress and measurable functional gains were not reported. Moreover, there is no documentation regarding body mass index that may warrant water-based therapy. There is also no documentation stating the need for reduced weight bearing. Therefore, the request for Aqua therapy 2x6 for the lumbar is not medically necessary.

MRI of the lumbar 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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303-304. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back Section, MRI

Decision rationale: As stated on pages 303-304 of the ACOEM Practice Guidelines, 2nd Edition (2004) referenced by CA MTUS, imaging of the lumbar spine is recommended in patients with red flag diagnoses where plain film radiographs are negative; unequivocal objective findings that identify specific nerve compromise on the neurologic examination, failure to respond to treatment, and consideration for surgery. In addition, Official Disability Guidelines recommends MRI for the lumbar spine for uncomplicated low back pain, with radiculopathy, after at least 1 month conservative therapy, sooner if severe or progressive neurologic deficit. In this case, rationale for the request was not provided. The MRI of the lumbar spine dated October 2012 revealed 6mm disc protrusion at L4-L5 on the right side compressing on the nerve root at L4-L5 and L5-S1. In the recent clinical evaluation, the patient still complains of low back pain with findings of L4-L5 and L5-S1 hypoesthesia and positive straight leg raise test. However, the documentation did not describe any significant worsening of symptoms. There was also no discussion regarding failure to respond to other methods of treatment. There is insufficient information to warrant a repeat lumbar MRI at this time. Therefore, request for MRI of the lumbar spine is not medically necessary.