

Case Number:	CM14-0044829		
Date Assigned:	04/22/2014	Date of Injury:	02/03/2014
Decision Date:	03/24/2015	UR Denial Date:	03/27/2014
Priority:	Standard	Application Received:	04/13/2014

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. 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, Arizona
 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 47-year-old male who reported an injury on 02/03/2014. The mechanism of injury occurred when he was loading boxes onto a van. His diagnoses included thoracic musculoligamentous sprain/strain, lumbosacral musculoligamentous sprain/strain with radiculitis, and lumbosacral spine discogenic disease. Past treatments included interferential unit, physical therapy, and a hot and cold unit. On 03/17/2014, the injured worker complained of back pain and sleeping problems. The physical examination revealed tenderness to the thoracic spine, spasms and trigger points bilaterally to the mid/lower thoracic region, decreased range of motion. There was also tenderness to the lumbar spine with spasms, decreased range of motion, positive straight leg raise on the left, and decreased motor strength in the left lower extremity, decreased sensation to the left anterolateral thigh/anterior knee/medial leg. The treatment plan included a lumbar brace, interferential unit, hot/cold unit, urine toxicology for medication monitoring. His relevant medications were not provided for review. A Request for Authorization form was submitted on 03/10/2014.

IMR ISSUES, DECISIONS AND RATIONALES

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

Retrospective (DOS: 3/17/2014): Urine toxicology test: 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, Urine screening

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Drug testing Page(s): 43.

Decision rationale: The request for Retrospective (DOS: 3/17/2014): Urine toxicology test is not medically necessary. According to the California MTUS Guidelines, drug testing is recommended to assess for the use or the presence of illegal drugs and monitoring of opioid regimen patients. The injured worker was indicated to have been ordered a urine drug screen on 03/17/2014. However, there was lack of documentation to indicate the injured worker needed assessment for the presence of illegal drugs. There was also lack of documentation in regards to opioid medications. In the absence of the above, the request is not supported by the evidence based guidelines. As such, the request is not medically necessary.

Retrospective (DOS: 3/17/2014): Interferential unit: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Interferential Unit Page(s): 118-120.

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

Decision rationale: The request for Retrospective (DOS: 3/17/2014): Interferential unit is not medically necessary. According to the California MTUS Guidelines, interferential units are not recommended as an isolated intervention. However, the guidelines do set selection criteria should an interferential unit be used to include: pain that has not been effectively controlled due to diminished effectiveness of medications or their side effects, history of substance abuse, significant pain from postoperative conditions that limit the ability to perform exercise programs or physical therapy treatments, and unresponsiveness to conservative measures. The injured worker was indicated to have been prescribed an interferential unit on 03/17/2014. However, there was lack of documentation the injured worker had met the following criteria to include pain that has not been effectively controlled due to diminished effectiveness of medications or their side effects, had a history of substance abuse, had significant pain from postoperative conditions limiting exercise programs or physical therapy, and had an unresponsiveness to conservative measures. In the absence of the above, the request is not supported by the evidence based guidelines. As such, the request is not medically necessary.

Retrospective (DOS: 3/17/2014): Hot/cold unit provided: 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, Cold packs

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 289-300. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) low back, cold/heat therapy, continuous flow cryotherapy unit.

Decision rationale: The request for Retrospective (DOS: 3/17/2014): Hot/cold unit provided is not medically necessary. According to the California MTUS/ACOEM Guidelines, physical modalities have no proven efficacy in treating acute low back symptoms. Furthermore, the Official Disability Guidelines indicate that cold/heat therapy, such as continuous flow cryotherapy units or heating unit would not be indicated in the acute phase for treating acute low back pain. Furthermore, heat and cold applications can be just as effective at home as those performed by therapists. There was lack of evidence indicating the medical necessity for a hot or cold unit as heat and cold applications may be just as effective when treated at home as provided by a therapist. Furthermore, the continuous flow cryotherapy or heating unit would not be medically necessary for the treatment in acute phases. There was lack of a clear rationale to indicate medical necessity for a hot/cold unit. Based on the above, the request is not supported by the evidence based guidelines. As such, the request is not medically necessary.

Physical functional capacity evaluation: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Functional capacity evaluation Page(s): 125. Decision based on Non-MTUS Citation ACOEM guidelines Chapter 7, page 138 Functional capacity evaluations

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 5 Cornerstones of Disability Prevention and Management Page(s): 88-89.

Decision rationale: The request for physical functional capacity evaluation is not medically necessary. A functional capacity evaluation is used in managing delayed recovery; it is indicated to document the patient's current state of functional ability, recovery trajectory to date as a timeline, to include the patient's complete history, objective observers, employee or on site occupational health profession, with regard to ability and effective set goals. The functional assessments are also indicated for patients who have severe causes of delayed functional recovery that require close management, rather than simple care. It is also indicated for the entering into the work hardening program. The injured worker had an injury date of 02/03/2014. However, the current physical exam failed to provide documentation of severe limitations indicating the injured worker required an extensive functional capacity evaluation due to a severe interrelated functional recovery that required close management rather than simple care. There was also lack of documentation to indicate the injured worker has had correlating tests to include diagnostic studies and conservative treatments prior to the recommendation of a functional capacity evaluation. In addition, there was lack of documentation the injured worker would be entering into the work hardening program. Based on the above, the request is not supported by the evidence based guidelines. As such, the request is not medically necessary.