

Case Number:	CM15-0123195		
Date Assigned:	07/07/2015	Date of Injury:	02/24/2015
Decision Date:	08/04/2015	UR Denial Date:	06/16/2015
Priority:	Standard	Application Received:	06/25/2015

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: Maryland

Certification(s)/Specialty: Physical Medicine & Rehabilitation, Neuromuscular 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 33 year old male, who sustained an industrial injury on February 24, 2015. He reported pain to the head, neck and lower back. Treatment to date has included work restrictions and medications. Currently, the injured worker complains of pain in the cervical spine, lumbar spine, thoracic spine and headache. He describes his cervical spine pain as moderate and dull. The cervical spine pain is aggravated when he looks up or turns his head. His thoracic spine and lumbar spine pain is described as frequent moderate sharp pain and this pain is aggravated with standing and prolonged sitting. The reports having a headache which is constant severe pain with associated tingling. The headache increases with driving. He reports that he can barely stand, push and pull. He has pain when lifting heavy items, driving a car, dressing, cooking, washing dishes, sleep and prolonged sitting. He uses ibuprofen for pain as needed. On physical examination the injured worker has spasm and tenderness to palpation at the bilateral cervical paraspinal muscles and the bilateral lumbar paraspinal muscles. He reports pain with active range of motion of the lumbar spine and the range of motion is limited. His muscle strength and sensation were within normal limits in the bilateral lower extremities. The diagnoses associated with the request include cervical disc herniation without myelopathy, lumbar disc displacement without myelopathy, thoracic spine sprain/strain, post-concussion syndrome and tension headache. The treatment plan includes twelve visits of physical therapy, multi-level interferential stimulator, Topical compounds, and lumbosacral orthosis.

IMR ISSUES, DECISIONS AND RATIONALES

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

Multi Interferential Stimulator 1 month rental: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Transcutaneous electrotherapy ,Interferential Current Stimulation (ICS) Page(s): 114-116, 120.

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

Decision rationale: Multi Interferential Stimulator 1 month rental is not medically necessary per the MTUS Chronic Pain Medical Treatment Guidelines. The guidelines state that the interferential unit 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. Additionally, the MTUS guidelines state: that an interferential unit requires a one-month trial to permit the physician and physical medicine provider to study the effects and benefits. There should be evidence of increased functional improvement, less reported pain and evidence of medication reduction. The MTUS states that while not recommended as an isolated intervention an interferential unit can be considered if pain is ineffectively controlled due to diminished effectiveness of medications; for post operative use; history of substance abuse; or unresponsive to conservative measures. The documentation does not indicate that the patient meets these criteria therefore this request is not medically necessary.

Lumbar Support Orthosis specifically Apollo ISO or equivalent L0637: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 298, 301. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) low back & lumbar support.

Decision rationale: Lumbar Support Orthosis specifically Apollo ISO or equivalent L0637 is not medically necessary per the MTUS ACOEM Guidelines. The guidelines state that lumbar supports have not been shown to have any lasting benefit beyond the acute phase of symptom relief. The MTUS guidelines also state that there is no evidence for the effectiveness of lumbar supports in preventing back pain in industry. Furthermore, the guidelines state that the use of back belts as lumbar support should be avoided because they have been shown to have little or no benefit, thereby providing only a false sense of security. The guidelines state that proper lifting techniques and discussion of general conditioning should be emphasized. The ODG states that a back brace can be used in spondylolisthesis, documented instability, and for treatment of nonspecific LBP (very low-quality evidence.) The documentation submitted does not reveal instability or extenuating reasons to necessitate a lumbar brace and therefore the request for lumbar support orthosis is not medically necessary.

