MAXIMUS Federal Services

Case Number:	CM15-0124529		
Date Assigned:	07/09/2015	Date of Injury:	03/03/2015
Decision Date:	08/05/2015	UR Denial Date:	06/15/2015
Priority:	Standard	Application Received:	06/29/2015

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 Jersey, Alabama, California
Certification(s)/Specialty: Neurology, 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 47 year old male, who sustained an industrial injury on 3/3/2015. The mechanism of injury was a slip and fall. The injured worker was diagnosed as having lumbar and cervical sprain/strain, left hip sprain/strain and lumbosacral disc desiccation. Lumbar magnetic resonance imaging showed a desiccated disc and diffuse disc bulge at lumbar 5-sacral 1. Treatment to date has included therapy and medication management. In a progress note dated 6/4/2015, the injured worker complains of low back pain radiating to the upper left thigh, neck pain with headaches, upper back pain, bilateral shoulder pain and right lower extremity pain. Physical examination showed tenderness in the cervical and lumbar spine. The treating physician is requesting aquatic therapy for the back and left hip, 2 times a week for 6 weeks, quantity: 12 sessions, home interferential unit and a lumbosacral orthosis.

IMR ISSUES, DECISIONS AND RATIONALES

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

Aquatic therapy for the back and left hip, 2 times a week for 6 weeks, quantity: 12 sessions: Upheld

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

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

Decision rationale: According to MTUS guidelines, aquatic therapy is "recommended as an optional form of exercise therapy, where available, as an alternative to land based physical therapy. Aquatic therapy (including swimming) can minimize the effects of gravity, so it is specifically recommended where reduced weight bearing is desirable, for example extreme obesity. For recommendations on the number of supervised visits, see Physical medicine. Water exercise improved some components of health-related quality of life, balance, and stair climbing in females with fibromyalgia, but regular exercise and higher intensities maybe required to preserve most of these gains. (Tomas-Carus, 2007)." There no clear evidence that the patient has difficulty performing land based physical therapy or the need for the reduction of weight bearing to improve the patient ability to perform particular exercise regimen. There is no documentation for a clear benefit expected from Aquatic therapy. Therefore the prescription of 12 aquatic therapy sessions for the back and left hip is not medically necessary.

Home IF (Interferential) unit, quantity: 1: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Interferential Current Stimulation Page(s): 118-119.

Decision rationale: According to MTUS guidelines, "Interferential Current Stimulation (ICS). 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. (Van der Heijden, 1999) (Werner, 1999) (Hurley, 2001) (Hou, 2002) (Jarit, 2003) (Hurley, 2004) (CTAF, 2005) (Burch, 2008) The findings from these trials were either negative or non-interpretable for recommendation due to poor study design and/or methodologic issues." "While not recommended as an isolated intervention, Patient selection criteria if Interferential stimulation is to be used anyway: Possibly appropriate for the following conditions if it has documented and proven to be effective as directed or applied by the physician or a provider licensed to provide physical medicine: Pain is ineffectively controlled due to diminished effectiveness of medications; or Pain is ineffectively controlled with medications due to side effects; or History of substance abuse; or Significant pain from postoperative conditions limits the ability to perform exercise programs/physical therapy treatment; or Unresponsive to conservative measures (e.g., repositioning, heat/ice, etc.)." In this case, there is no clear evidence that the patient did not respond to conservative therapies, or have pain that limit his ability to perform physical therapy. There is no clear documentation of failure of pharmacological treatments or TENS therapy. Therefore, the prescription of IF unit is not medically necessary.

Lumbosacral orthosis, quantity: 1: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 298.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 301.

Decision rationale: According to MTUS guidelines, lumbar supports have not been shown to have any lasting benefit beyond the acute phase of symptom relief. A lumbar corset is recommended for prevention and not for treatment. Therefore, the request for Lumbosacral orthosis is not medically necessary.