

Case Number:	CM15-0063695		
Date Assigned:	05/13/2015	Date of Injury:	04/27/2013
Decision Date:	06/17/2015	UR Denial Date:	03/30/2015
Priority:	Standard	Application Received:	04/03/2015

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: Internal 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 49 year old male, who sustained an industrial injury on 4/27/13. He has reported initial complaints of sharp pain in the right groin after lifting a 331-pound barrel. The diagnoses have included lumbosacral strain/sprain, lumbosacral degenerative osteophytes and multilevel disc bulge, right groin pain and numbness status post repair, gastritis secondary to medications and depression. Treatment to date has included medications, surgery, diagnostics, physical therapy, Functional Capacity Evaluation (FCE), activity modifications. Currently, as per the physician progress note dated 3/19/15, the injured worker complains of lumbosacral pain rated 9/10 on pain scale and constant. He complains of radicular symptoms right lower extremity (RLE) to foot. There is giving away in the left leg with occasional radicular symptoms in the left lower extremity (LLE). He complains of increased low back pain with prolonged activity. He reports that previous physical therapy of 24 sessions was very helpful and beneficial. The physician noted that he will request more physical therapy since prior treatments were helpful and he is apprehensive about injections or surgery. The diagnostic testing that was performed included Magnetic Resonance Imaging (MRI) of the lumbar spine dated 6/27/14 revealed disc tear and disc bulge. The current medications included Motrin for pain. There was previous therapy sessions noted in the records. Work status is return to modified duty with restrictions on 3/19/15. The physician requested treatments included 6 Physical therapy sessions for lumbar spine; Lumbar spine corset brace and Transcutaneous electrical nerve stimulation (TENS) unit times one month home based trial.

IMR ISSUES, DECISIONS AND RATIONALES

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

6 Physical therapy sessions for lumbar spine: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Therapy (PT) Physical Medicine Pages 98-99. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain (Chronic) Physical medicine treatment. ODG Preface Physical Therapy Guidelines.

Decision rationale: Medical Treatment Utilization Schedule (MTUS) Chronic Pain Medical Treatment Guidelines provide physical therapy (PT) physical medicine guidelines. For myalgia and myositis, 9-10 visits are recommended. For neuralgia, neuritis, and radiculitis, 8-10 visits are recommended. Patients are instructed and expected to continue active therapies at home as an extension of the treatment process in order to maintain improvement levels. Home exercise can include exercise with or without mechanical assistance or resistance and functional activities with assistive devices. The medical records document a history of lumbar spine sprain and strain with herniated lumbar disc, right knee sprain and strain with tendinosis, status post right inguinal hernia repair. No evidence of lumbosacral radiculopathy on EMG/NCV of the lumbar spine 6/4/14. Date of injury was 4/27/13. The primary treating physician's progress report dated 3/19/15 documented that the patient had prior PT physical therapy 24 times (24x). The progress report noted that past physical therapy was helpful. The dates of the PT physical therapy visits were not documented. The patient stated prior therapy was helpful, but the specific elements of functional improvement were not documented. Per Medical Treatment Utilization Schedule (MTUS) definitions, functional improvement means either a clinically significant improvement in activities of daily living or a reduction in work restrictions, and a reduction in the dependency on continued medical treatment. Per ODG, patients should be formally assessed after a six visit clinical trial to evaluate whether PT has resulted in positive impact, no impact, or negative impact prior to continuing with or modifying the physical therapy. When treatment duration and/or number of visits exceed the guideline, exceptional factors should be noted. The patient has complete 24 visits of physical therapy in the past. Without documented specific functional improvement, the request for 6 visits of physical therapy exceeds MTUS guidelines, and is not supported. Therefore, the request for physical therapy is not medically necessary.

Lumbar spine corset brace: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 298, 301, Tables 12-5 and 12-8. Decision based on Non-MTUS Citation Online Official Disability Guidelines (ODG) - http://www.odg-twc.com/odgtwc/low_back.htm#Lumbar supports.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 301. Decision based on Non-MTUS Citation ACOEM 3rd edition Low back disorders 2011 <http://www.guideline.gov/content.aspx?id=38438>.

Decision rationale: Medical Treatment Utilization Schedule (MTUS) addresses lumbar supports. American College of Occupational and Environmental Medicine (ACOEM) 2nd Edition (2004) Chapter 12 Low Back Complaints (Page 301) states that lumbar supports have not been shown to have any lasting benefit beyond the acute phase of symptom relief. ACOEM 3rd edition occupational medicine practice guidelines (2011) state that lumbar supports are not recommended for the treatment of low back disorders. Lumbar supports are not recommended for prevention of low back disorders. The medical records document a history of lumbar spine sprain and strain with herniated lumbar disc, right knee sprain and strain with tendinosis, status post right inguinal hernia repair. No evidence of lumbosacral radiculopathy on EMG/NCV of the lumbar spine 6/4/14. Date of injury was 4/27/13. The primary treating physician's progress report dated 3/19/15 documented low back pain. Range of motion of the lumbar spine demonstrated flexion 45 degrees, extension 15 degrees, and lateral rotation 20 degrees. Medical records document a history of low back conditions. MTUS and ACOEM guidelines do not support the medical necessity of lumbar supports. Therefore, the request for lumbar spine corset brace is not medically necessary.

Neurostimulator TENS-EMS unit times one month home based trial: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines TENS and H-wave stimulation (HWT).

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints, Chapter 13 Knee Complaints Page(s): 300, 308-310, 339, 346-347, Chronic Pain Treatment Guidelines Transcutaneous electrotherapy Page 114-121. Electrical stimulators (E-stim) Page 45. Functional restoration programs (FRPs) Page 49. Decision based on Non-MTUS Citation ACOEM 3rd Edition Knee disorders 2011 <http://www.guideline.gov/content.aspx?id=36632>.

Decision rationale: Medical Treatment Utilization Schedule (MTUS) addresses transcutaneous electrotherapy. MTUS Chronic Pain Medical Treatment Guidelines indicates that several published evidence-based assessments of transcutaneous electrical nerve stimulation (TENS) have found that evidence is lacking concerning effectiveness. American College of Occupational and Environmental Medicine (ACOEM) 2nd Edition (2004) Chapter 12 Low Back Complaints (Page 300) indicates that physical modalities such as diathermy, ultrasound, transcutaneous electrical neurostimulation (TENS) units, percutaneous electrical nerve stimulation (PENS) units, and biofeedback have no proven efficacy in treating acute low back symptoms. Insufficient scientific testing exists to determine the effectiveness of these therapies. Table 12-8 Summary of Recommendations for Evaluating and Managing Low Back Complaints (Page 308) indicates that TENS is not recommended. American College of Occupational and Environmental Medicine (ACOEM) 2nd Edition (2004) Chapter 13 Knee Complaints (Page 339) states that physical modalities, such as massage, diathermy, cutaneous laser treatment, ultrasound, and biofeedback have no scientifically proven efficacy in treating acute knee symptoms. Other miscellaneous therapies have been evaluated and found to be ineffective.

Table 13-6 Summary of Recommendations for Evaluating and Managing Knee Complaints (Page 346-347) indicates that regarding physical treatment methods, passive modalities without exercise program are not recommended. ACOEM 3rd Edition does not recommend transcutaneous electrical stimulation (TENS) for knee pain. MTUS Chronic Pain Medical Treatment Guidelines (Page 121) indicates that neuromuscular electrical stimulation (NMES) is not recommended. There is no evidence to support its use in chronic pain. There are no intervention trials suggesting benefit from NMES for chronic pain. The medical records document a history of lumbar spine sprain and strain with herniated lumbar disc, right knee sprain and strain with tendinosis, status post right inguinal hernia repair. Date of injury was 4/27/13. The primary treating physician's progress report dated 3/19/15 documented low back pain. Medical records document a history of low back and knee complaints. MTUS and ACOEM guidelines do not support the request for transcutaneous electrical nerve stimulation (TENS) and neuromuscular electrical stimulation (NMES) for low back and knee complaints. Therefore, the request for a neurostimulator TENS-EMS unit is not medically necessary.