

Case Number:	CM15-0064431		
Date Assigned:	04/10/2015	Date of Injury:	05/30/2002
Decision Date:	06/01/2015	UR Denial Date:	04/02/2015
Priority:	Standard	Application Received:	04/06/2015

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: 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 66-year-old female, who sustained an industrial injury on 05/30/2002. The injured worker is currently diagnosed as having Displacement of lumbar intervertebral disc without myelopathy, lumbago, medial meniscus tear, multiple sprain/strain except fingers/toes, and shoulder impingement syndrome. Treatment to date has included home health aide, injection, wrist brace, and medications. In a progress note dated 03/11/2015, the injured worker presented with complaints of thoraco-lumbar spine pain. The treating physician reported requesting authorization for podiatry consultation, spine specialist consultation for laser treatment, and an interferential unit.

IMR ISSUES, DECISIONS AND RATIONALES

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

PODIATRY CONSULT: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disabilities Guidelines.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation ACOEM Practice Guidelines, 2nd Edition (2004), Independent medical examination and consultations Ch: 7 page 127.

Decision rationale: Based on the 03/11/15 progress report provided by treating physician, the patient presents with thoraco-lumbar spine pain rated 6/10. The request is for podiatry consult. Patient's diagnosis per Request for Authorization form dated 03/26/15 includes Displacement of lumbar intervertebral disc without myelopathy and Lumbar Spinal Stenosis. Physical examination on 03/11/15 revealed global tenderness with loss of motion and decreased strength to the lumbar spine. Treatment to date has included home health aide, injection, wrist brace, and medications. Hydrocodone has been dispensed on 03/11/15 "To alleviate pain and discomfort." The patient may return to modified duty, per 03/11/15 report. Treatment report were provided from 02/12/14 - 03/11/15. ACOEM Practice Guidelines, 2nd Edition (2004), Chapter 7 page 127 has the following: "The occupational health practitioner may refer to other specialists if a diagnosis is uncertain or extremely complex, when psychosocial factors are present, or when the plan or course of care may benefit from additional expertise." ACOEM guidelines further states, referral to a specialist is recommended to aid in complex issues. Per 03/11/15 progress report, treater states, "I am requesting authorization for this patient to be seen by [REDACTED], to address the patient's complaints of symptoms." In this case, treater does not explain why a podiatry consultation is needed. There is no mention of foot issues or symptoms, positive examination findings and how the patient is struggling with chronic pain to benefit from a podiatrist consultation. There is no medical rationale provided for the necessity of podiatry consult. Therefore, the request is not medically necessary.

CONSULT WITH A SPINE SPECIALIST FOR LASER TREATMENT: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Low-Level Laser Therapy (LLLT) Page(s): 57.

Decision rationale: Based on the 03/11/15 progress report provided by treating physician, the patient presents with thoraco-lumbar spine pain rated 6/10. The request is for consult with a spine specialist for laser treatment. Patient's diagnosis per Request for Authorization form dated 03/26/15 includes Displacement of lumbar intervertebral disc without myelopathy and Lumbar Spinal Stenosis. Physical examination on 03/11/15 revealed global tenderness with loss of motion and decreased strength to the lumbar spine. Treatment to date has included home health aide, injection, wrist brace, and medications. Hydrocodone has been dispensed on 03/11/15 "to alleviate pain and discomfort." The patient may return to modified duty, per 03/11/15 report. Treatment report were provided from 02/12/14 - 03/11/15. MTUS Guidelines, page 57 states "Low-Level Laser Therapy (LLLT): Not recommended." The Guidelines also suggest, "Given the equivocal or negative outcomes from a significant number of randomized clinical trials, it must be concluded that the body of evidence does not allow conclusions other than that the treatment of most pain syndromes with low level laser therapy provides at best the equivalent of a placebo effect." Per 03/11/15 progress report, treater states, "I am requesting authorization for a spine specialist consultation for laser treatment." While the patient may benefit from consult with spine specialist, treater does not explain why laser treatment is necessary, or would be a better option for this patient, when compared to other proven conservative treatment modalities. Additionally, MTUS guidelines do not support laser therapy. Therefore, the request is not medically necessary.

INTERFERENTIAL UNIT 30-60 DAYS RENTAL, PURCHASE IF EFFECTIVE: Upheld

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

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

Decision rationale: Based on the 03/11/15 progress report provided by treating physician, the patient presents with thoraco-lumbar spine pain rated 6/10. The request is for interferential unit 30-60 days rental, purchase if effective. Patient's diagnosis per Request for Authorization form dated 03/26/15 includes Displacement of lumbar intervertebral disc without myelopathy and Lumbar Spinal Stenosis. Physical examination on 03/11/15 revealed global tenderness with loss of motion and decreased strength to the lumbar spine. Treatment to date has included home health aide, injection, wrist brace, and medications. Hydrocodone has been dispensed on 03/11/15 "To alleviate pain and discomfort." The patient may return to modified duty, per 03/11/15 report. Treatment report were provided from 02/12/14 - 03/11/15. MTUS pages 118-120, under Interferential Current Stimulation has the following regarding ICS units: 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.) If those criteria are met, then a one-month trial may be appropriate 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. Per 03/11/15 progress report, treater states "I am requesting authorization for the patient to receive a interferential unit for 30-60 day rental and purchase if effective for long term with supplies as needed to manage pain and restore function." Treater has not discussed reason for the request, nor how the device will be used, or what body part will be treated. In this case, there is no evidence that pain is not effectively controlled due to the effectiveness of medication, substance abuse or pain due to postoperative conditions or unresponsiveness to conservative measures. Furthermore, IF unit is indicated for a one-month trial and the request is for 30-60 days. This request is not in accordance with guideline recommendations. Therefore, the request is not medically necessary.