

Case Number:	CM15-0068098		
Date Assigned:	04/15/2015	Date of Injury:	03/13/2013
Decision Date:	05/14/2015	UR Denial Date:	03/16/2015
Priority:	Standard	Application Received:	04/10/2015

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: Ohio, North Carolina, Virginia
Certification(s)/Specialty: Family Practice

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 53-year-old female, with a reported date of injury of 03/13/2013. The diagnoses include lumbar radiculitis/radiculopathy. Treatments to date have included an MRI of the low back, electrodiagnostic studies, x-rays of the low back, oral medications, and physical therapy. The initial orthopedic comprehensive report dated 02/23/2015 indicates that the injured worker complained of low back pain, rated 6 out of 10. The pain radiated to the right leg and right foot. She also complained of intermittent right leg pain, which was rated 9 out of 10. The pain radiated to her gluteus muscles, and foot. The physical examination showed an abnormal gait with a limp in the right leg, decreased lumbar range of motion, decreased lumbar lordosis, positive bilateral straight leg raise test with pain in the L5-S1 dermatome distribution, tightness and spasm of the lumbar bilateral paraspinal musculature, facet joint tenderness at the bilateral L4 and L4, reduced sense of touch at the anterolateral aspect of the foot and ankle, and normal bilateral ankle range of motion. The treating physician requested an interferential (IF) unit for home use for pain relief, a LSO brace for support and relief, and physiotherapy for the lumbar spine.

IMR ISSUES, DECISIONS AND RATIONALES

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

IF Unit for home use for pain relief: Overturned

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

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

Decision rationale: Interferential current stimulation 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. 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. A jacket should not be certified until after the one-month trial and only with documentation that the individual cannot apply the stimulation pads alone or with the help of another available person. In this instance, the injured worker has not improved with medication and 5 sessions of chiropractic. It is clear that the treating physician intends to have the unit used in conjunction with physical therapy and medication and therefore this would not be an isolated intervention. Therefore, a one month trial with an interferential current stimulator is medically necessary.

LSO brace for support and relief: Overturned

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Low Back chapter, Lumbar supports section.

Decision rationale: Lumbar supports are recommended as an option for compression fractures and specific treatment of spondylolisthesis, documented instability, and for treatment of nonspecific LBP (very low-quality evidence, but may be a conservative option). Under study for post-operative use. In this instance, it may be said that the injured worker has non-specific low back pain as the lower extremity electrodiagnostic studies were normal and the lumbar MRI was relatively benign. Therefore, an LSO brace is medically necessary in this instance.

Physiotherapy 2x6 for the lumbar spine: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines. Low Back chapter. Physical therapy section.

Decision rationale: ODG Physical Therapy Guidelines Allow for fading of treatment frequency (from up to 3 or more visits per week to 1 or less), plus active self-directed home PT. Also see other general guidelines that apply to all conditions under Physical Therapy in the ODG Preface, including assessment after a "six-visit clinical trial." Lumbar sprains and strains (ICD9 847.2):- 10 visits over 8 weeks-Sprains and strains of unspecified parts of back (ICD9 847): 10 visits over 5 weeks, Sprains and strains of sacroiliac region (ICD9 846): Medical treatment: 10 visits over 8 weeks, Lumbago; Backache, unspecified (ICD9 724.2; 724.5): 9 visits over 8 Weeks. Intervertebral disc disorders without myelopathy (ICD9 722.1; 722.2; 722.5; 722.6; 722.8):Medical treatment: 10 visits over 8 weeks. In this instance, the injured worker has been diagnosed with a lumbar musculoligamentous strain and lumbar radiculitis. She completed only one physical therapy session to date per the latest records available. The requested number of physical therapy sessions, 12, exceeds the number recommended by the guidelines for these conditions. Therefore, physiotherapy two times a week for 6 weeks is not medically necessary.