MAXIMUS Federal Services

Case Number:	CM15-0075762		
Date Assigned:	04/27/2015	Date of Injury:	01/19/2015
Decision Date:	05/29/2015	UR Denial Date:	03/27/2015
Priority:	Standard	Application Received:	04/21/2015

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: Emergency 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 57 year old male, who sustained an industrial injury on 1/19/15. The injured worker has complaints of low back pain and left medial ankle, heel and bottom of the foot pain. The diagnoses have included lumbago and sprain of lumbosacral (joint) (ligament). Treatment to date has included home exercise program and physical therapy. The request was for magnetic resonance imaging (MRI) of the lumbar spine and multi stimulation unit plus supplies x 3 months.

IMR ISSUES, DECISIONS AND RATIONALES

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

MRI lumbar spine: 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): 303-305.

Decision rationale: The requested MRI lumbar spine, is not medically necessary. CA MTUS, ACOEM 2nd Edition, 2004, Chapter 12, Lower Back Complaints, Special Studies and Diagnostic and Therapeutic Considerations, Pages 303-305, recommend imaging studies of the lumbar spine with "Unequivocal objective findings that identify specific nerve compromise on the neurological examination are sufficient evidence to warrant imaging in patients who do not respond to treatment and who would consider surgery an option." The injured worker has low back pain and left medial ankle, heel and bottom of the foot pain. The treating physician has not documented a positive straight leg raising test, nor deficits in dermatomal sensation, reflexes or muscle strength. The request for MRI lumbar spine is not medically necessary.

Multi stim unit plus supplies x3 months: Upheld

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

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

Decision rationale: The requested Multi stim unit plus supplies x 3 months, is not medically necessary. CA Chronic Pain Medical Treatment Guidelines, Transcutaneous electrotherapy, Interferential current stimulation, Page 118-120, noted that this treatment 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. There are no published randomized trials comparing TENS to Interferential current stimulation;" and the criteria for its use are: "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.)." The injured worker has low back pain and left medial ankle, heel and bottom of the foot pain. The treating physician has not documented any of the criteria noted above, nor a current functional rehabilitation treatment program, nor derived functional improvement from electrical stimulation including under the supervision of a licensed physical therapist. The request for Multi stim unit plus supplies x3 months is not medically necessary.