

Case Number:	CM13-0007775		
Date Assigned:	11/27/2013	Date of Injury:	02/07/2013
Decision Date:	02/07/2014	UR Denial Date:	07/12/2013
Priority:	Standard	Application Received:	08/05/2013

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Physical Medicine & Rehabilitation and is licensed to practice in Oklahoma and Texas. 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 physician 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/services.

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 patient is a 34-year-old female who reported an injury on 02/07/2013 after she slipped and fell at work which has resulted in pain, numbness and weakness at the neck, right shoulder, arm, hand, fingers, lower back and right leg. After reporting the incident to her supervisor she underwent x-rays at the time for the right shoulder and right hand which demonstrated no evidence of a fracture. The patient utilized ibuprofen on her own and began a course of physical therapy for persistent pain. She received a total of approximately 16 physical therapy sessions, but reported only having short-term relief. The patient continued with a home exercise program but continued to have persistent symptoms. She underwent MRI of the cervical spine on June 22, 2013 which noted mild degenerative changes of the cervical spine. The patient also stated that in addition to her continuous neck pain radiating to the lower back, her right lower leg also gives way at times. The patient has been diagnosed as having cervical DJD, lumbar radiculitis, and severe head pain. However, on October 7, 2013, the patient underwent EMG/nerve conduction velocity study of the upper extremities which demonstrated no abnormalities. The most recent clinical notes dated October 21, 2013 stated the patient still has some intermediate discomfort in the right side of her neck which radiates into the right trapezius region. She did note some mild improvement with less tingling in the right hand, but still has occasional discomfort in the right hip. The physician is now requesting MRI of the lumbar spine with contrast.

IMR ISSUES, DECISIONS AND RATIONALES

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

Pain Management Referral: Overturned

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation American College of Occupational and Environmental Medicine (ACOEM) Guidelines, Chapter 7, page(s) 127

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines.

Decision rationale: California Medical Treatment Utilization Schedule (MTUS) Guidelines state that if the complaint persists, the physician needs to reconsider the diagnosis and decide whether a specialist evaluation is necessary. As in the case of this patient, she has had ongoing treatment for her chronic cervical and low back pain which has not provided significant improvement. At this time, a referral to a pain management specialist is considered appropriate considering the delayed improvement from this patient's injury. Therefore, the requested service for a referral to pain management is considered appropriate and is certified.

Quad Combo electric stimulation unit: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation Title 8: Industrial Relations, Division 1 Department of Industrial Relations, Chapter 4.5 Division of Workers' Compensation, Subchapter 1 Administrative Director - Administrative Rules, Article 5.5.2

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Neuromuscular electrical stimulation (NMES devices), Transcutaneous electrotherapy Page(s): 121,. Decision based on Non-MTUS Citation <http://www.lgmedsupply.com/lg4in1qucote.html>

Decision rationale: Under California Medical Treatment Utilization Schedule (MTUS) it states neuromuscular electrical stimulation devices are not recommended as they are primarily as part of a rehabilitation program following stroke and there is no evidence to support its use in chronic pain. Because the device being requested is a name brand unit, under LGmedsupply.com, an on-line web site has been referred to in this case due to this site listing the name brand unit in question. According to LGmedsupply.com it states that the quad combo is a TENS unit, muscle stimulation, interferential unit, and micro-current all in one. Under California MTUS it states that TENS units are not recommended as a primary treatment modality, but a 1 month home-based TENS trial may be considered as a non-invasive conservative option, if used as an adjunct to a program of evidence-based functional restoration. The documentation does not state the patient has utilized this system for a 1 month home-based trial. According to a letter written by the patient that states that she currently obtains an LG super quad interferential unit, though neither the letter nor the other provided documentation indicate the patient is a primary owner of this equipment. It also does not state the patient is utilizing this in adjunct to any other objective-based conservative modality. Therefore, at this time, the medical necessity for the use of a quad combo cannot be established. Furthermore, without objective measurements providing the efficacy of the previous use not being included in the documentation, the requested service does not meet guideline criteria for continued use. As such, the requested service is non-certified.

Foam Roller: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Blue Cross of California Medical Policy Durable Medical Equipment CG-DME-10

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Knee and Leg Chapter, Durable medical equipment (DME).

Decision rationale: California Medical Treatment Utilization Schedule (MTUS) and American College of Occupational and Environmental Medicine (ACOEM) do not address the use of durable medical equipment. Therefore, Official Disability Guidelines (ODG) has been referred to in this case. Under ODG it states that durable medical equipment is defined as equipment which can withstand repeated use, could normally be rented and used by successive patients, is primarily and customarily used to serve a medical purpose, is generally not useful to a person in the absence of illness or injury, and is appropriate for use in a patient's home. In the case of this patient, she has noted in her letter that the foam roller is being used to provide her with the ability to relieve the significant persistent right neck, shoulder, and upper back muscle spasm. However, as the patient is noted to have an existing foam roller, the rationale for another roller has not been provided. As such, the requested service is non-certified.

Neck Traction: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation American College of Occupational and Environmental Medicine (ACOEM) Guidelines, Table 8-8, page 181; ODG-TWC Neck & Upper Back Procedure Summary last updated May 13, 2013

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 181-183,173.

Decision rationale: Under California Medical Treatment Utilization Schedule (MTUS) and American College of Occupational and Environmental Medicine (ACOEM) it states that traction, as a physical treatment method, is not recommended for evaluating and managing neck and upper back complaints. Although the patient has been having continuation of chronic cervical and lumbar pain, there is no high grade scientific evidence to support the effectiveness or ineffectiveness of passive physical modalities such as traction as a treatment method for acute regional neck pain. Therefore, in regard to the non-recommendation for the use of traction to treat the patient's cervical spinal discomfort, the requested service is non-certified.

Physical Therapy 3 times per week for 8 weeks: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Title 8: Industrial Relations, Division 1 Department of Industrial Relations, Chapter 4.5 Division of Workers' Compensation, Subchapter 1 Administrative Director - Administrative Rules, Article 5.5.2 Medical Treatment Utilization Schedule.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Page(s): 98-99.

Decision rationale: Under California MTUS, it states active therapy is based on the philosophy that therapeutic exercise and/or activity are beneficial for restoring flexibility, strength, endurance, function, range of motion, and can alleviate discomfort. Patients are instructed and expected to continue active therapies at home as an extension of the treatment process in order to maintain improvement levels. It also states that for patients with myalgia and myositis unspecified they are allowed 9 to 10 visits over 8 weeks and for neuralgia, neuritis, and radiculitis unspecified they are allowed 8 to 10 visits over 4 weeks. The documentation states the patient has already completed 16 sessions of physical therapy. Therefore, the requested service would exceed maximum allowance for California MTUS Guidelines. Furthermore, there is nothing in the documentation stating the patient has had extenuating circumstances or red flag issues to necessitate further treatment at this time. As such, the requested service is non-certified.

Massage Therapy 3 times per week for 8 weeks is not medically necessary and appropriate. This request is partially certified for 2 visits over 2 weeks (total of 4 massage therapy sessions): Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Title 8: Industrial Relations, Division 1 Department of Industrial Relations, Chapter 4.5 Division of Workers' Compensation, Subchapter 1 Administrative Director - Administrative Rules, Article 5.5.2 Medical Treatment Utilization Schedule.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Massage therapy.

Decision rationale: Under California Medical Treatment Utilization Schedule (MTUS), massage therapy is recommended as an option for treatment that should be used in adjunct to other recommended treatments such as exercise and should be limited to 4 to 6 visits in most cases. The patient stated she has already undergone 2 sessions of massage therapy which made a significant difference in her ability to get some relief and carry out her professional work more effectively. However, under California MTUS it further states that many studies lack long-term follow-up in the use of massage therapy, but there is a lack of long-term benefits that may only be due to the short treatment period or treatments such as these do not address the underlying cause of pain. The request for massage therapy 3 times a week for 8 weeks exceeds the 6 weeks limit for massage therapy under California MTUS Guidelines. Therefore, the requested service is partially-certified at 2 visits over 2 weeks in order to keep the patient within the 6 visits limit. Therefore, the request is partially-certified for a total of 4 massage therapy sessions.