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| <b>Case Number:</b>   | CM13-0008200 |                              |            |
| <b>Date Assigned:</b> | 09/13/2013   | <b>Date of Injury:</b>       | 07/18/2006 |
| <b>Decision Date:</b> | 02/04/2014   | <b>UR Denial Date:</b>       | 07/24/2013 |
| <b>Priority:</b>      | Standard     | <b>Application Received:</b> | 08/07/2013 |

### 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 Orthopedic Surgery, has a Fellowship trained in Spine Surgery and is licensed to practice in California. 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. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

### 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 45-year-old female who reported a work-related injury on 07/18/2006, as a result of a motor vehicle accident. The provider documents the patient presents for treatment of the following diagnoses: cervical muscle spasm, cervical radiculopathy, cervical sprain/strain, lumbar disc protrusion, lumbar myospasms, lumbar radiculopathy, lumbar sprain/strain, right shoulder impingement syndrome, right shoulder pain, right shoulder sprain/strain, status post strength to the right shoulder, right carpal tunnel syndrome, right wrist pain, right wrist sprain/strain, disruption of 24-hour sleep/wake cycle, insomnia with sleep apnea, loss of sleep, and sleep disturbance. The clinical note dated 11/05/2013 documents the patient was seen under the care of [REDACTED]. The provider documents upon physical exam of the patient, she continues to present with complaints of frequent, dull, achy, sharp cervical spine and low back pain. The provider documents the patient complains of intermittent dull, achy, right shoulder pain, as well as right wrist pain. The provider documented range of motion of the cervical spine was decreased and painful, and there was +3 tenderness to palpation of the cervical paravertebral muscles. The provider documented the range of motion of the patient's lumbar spine was decreased secondary to pain, as well as the right shoulder/right wrist range of motion decreased secondary to pain. The provider documented the patient was to continue with LINT for the lumbar spine to increase range of motion and ADLs and decrease pain. The provider documented the patient was to continue use of a TENS unit to help increase range of motion and decrease pain. The provider is recommending a new one, as the old unit is broken. The provider documented the patient was referred for consult with a podiatrist for pain to the low back, and custom orthotics to correct altered biomechanics, as well as orthopedic consult for the right wrist. The patient was to co

## IMR ISSUES, DECISIONS AND RATIONALES

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

### **Lumbar Spinal decompression (x12): Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM,Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG).

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 298-300.

**Decision rationale:** The Physician Reviewer's decision rationale: The current request is not supported. California MTUS/ACOEM indicates, "Because evidence is insufficient to support using vertebral axial decompression for treating low back injuries, it is not recommended." The clinical notes document the patient has utilized multiple conservative interventions for her pain complaints, to include decompression therapy/manipulative treatment. The clinical notes failed to document significant objective functional improvements evidencing positive efficacy of this intervention for the patient's pain complaints. Therefore, given the above, the request for lumbar spine decompression x12 is not medically necessary or appropriate.

### **Aqua Therapy (x12): Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM,Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG).

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines AQUATIC THERAPY, physical medicine, Page(s): 22,98-99.

**Decision rationale:** The Physician Reviewer's decision rationale: The current request is not supported. California MTUS indicates, "Aquatic therapy is recommended as an optional form of exercise therapy, where available, as an alternative to land-based physical therapy." Additionally, California MTUS indicates "to allow for fading of treatment frequency from up to 3 visits per week to 1 or less plus active self-directed home physical medicine. The clinical notes failed to document the patient's specific course of treatment, as far as recent supervised therapeutic interventions, duration, frequency, and efficacy of treatment. The patient presents some 7 years status post a work-related injury. At this point in the patient's treatment, an independent home exercise program would be indicated As such, the request for aqua therapy x12 is not medically necessary or appropriate.

### **Physical therapy: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM,Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG).

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 99.

**Decision rationale:** The Physician Reviewer's decision rationale: The current request is not supported. California MTUS indicates "to allow for fading of treatment frequency from up to 3 visits per week to 1 or less plus active self-directed home physical medicine. The clinical notes failed to document the patient's specific course of treatment, as far as recent supervised therapeutic interventions, duration, frequency, and efficacy of treatment. The patient presents some 7 years status post a work-related injury. At this point in the patient's treatment, an independent home exercise program would be indicated. As such, the request for physical therapy is not medically necessary or appropriate.

**Functional Capacity:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM, Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG).

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation American College of Occupational and Environmental Medicine (ACOEM), 2nd Edition, (2004) Chapter 7, pgs. 137-138.

**Decision rationale:** The Physician Reviewer's decision rationale: The current request is not supported. The clinical documentation submitted for review reports the patient continues to present with chronic pain complaints status post a work-related injury sustained in 2006. California MTUS/ACOEM indicates, "There is little scientific evidence confirming that FCEs predict an individual's actual capacity to perform in the workplace. An FCE reflects what an individual can do on a single day at a particular time." The clinical notes document the patient has not worked times multiple years, and underwent a prior QME, which assessed the patient's work status. Given the above, the request for a Functional Capacity Evaluation is not medically necessary or appropriate.