

<b>Case Number:</b>	CM13-0018500		
<b>Date Assigned:</b>	06/06/2014	<b>Date of Injury:</b>	03/09/2010
<b>Decision Date:</b>	07/21/2014	<b>UR Denial Date:</b>	08/23/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	08/29/2013

### 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. The expert reviewer is Board Certified in Internal Medicine, and is licensed to practice in California, Colorado, Kentucky, and North Carolina. 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/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 injured worker is a 55-year-old who reported an injury to several areas of her body occurring on March 09, 2010. The clinical note dated July 18, 2013 indicates the injured worker presenting with weakness throughout the whole body. There is an indication the injured worker underwent an arthroscopic procedure at the right shoulder and was referred for a course of rehabilitative therapy. The injured worker reported poor results and subsequently developed adhesive capsulitis at the right shoulder. The injured worker was also diagnosed with a cervical musculoligamentous sprain/strain. A previous MRI of the cervical spine revealed no significant disc bulges, spinal stenosis, or neuroforaminal narrowing. An MRI of the thoracic lumbar sacral region revealed mild degenerative disc desiccation at L4-5 without any disc space narrowing or mild deformity. The clinical note dated November 11, 2013 indicates the injured worker rating the pain as 8/10. The injured worker also reported issues with her sleep hygiene secondary to restless legs. The note indicates the injured worker utilizing Trazadone, Klonopin, and Effexor at that time. The clinical note dated January 7, 2014 indicates the injured worker complaining of low back pain as well as both elbows as well as cervical region pain. The clinical note dated December 16, 2013 indicates the injured worker being recommended for the use of Norco to address the pain complaints. The note indicates the injured worker continuing with complaints of pain in the neck, shoulders, upper extremities, low back, and lower extremities. The utilization review dated October 3, 2013 resulted in denials for an Orthostim 4 unit, home care, a consultation, aquatic therapy, acupuncture, and a psychological evaluation. Previously, the injured worker had undergone acupuncture therapy with no significant benefits. Therefore, the request for acupuncture was not fully supported. The request for the Orthostim 4 unit was not supported as no information had been submitted regarding additional modalities to address the injured worker's ongoing care. The request for home health care was denied as no information

had been submitted supporting the need in terms of the injured worker's current condition. The note indicates the injured worker having not been confined to her home and no evidence was submitted regarding the injured worker's inability to leave home without a considerable and taxing effort. The request for an MRI of the lumbar spine was not fully supported as no information had been submitted regarding any significant changes in comparison to the previous MRI of the lumbar spine. It does appear the injured worker was recommended for a consultation with an OBGYN (obstetrician/gynecologist) given the injured worker's ongoing urinary incontinence.

### **IMR ISSUES, DECISIONS AND RATIONALES**

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

#### **UNKNOWN AMOUNT OF AQUATIC THERAPY: Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Aquatic therapy Page(s): 22.

**Decision rationale:** The documentation indicates the injured worker complaining of pain at numerous areas. There is an indication the injured worker has previously undergone aquatic therapy with no significant benefit. The continuation of aquatic therapy is indicated for injured workers who have demonstrated a positive response to the previously rendered treatment. Given that no objective data was submitted confirming the injured worker's positive response to previous aquatic therapy, this request is not indicated. Additionally, aquatic therapy is recommended for injured workers who are unable to perform land based activities. There is no indication that the injured worker is unable to perform any land based activities. The request for an unknown amount of aquatic therapy is not medically necessary or appropriate.

#### **UNKNOWN AMOUNT OF ACUPUNCTURE: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Acupuncture Treatment Guidelines.

**MAXIMUS guideline:** Decision based on MTUS Acupuncture Treatment Guidelines.

**Decision rationale:** Acupuncture treatment is indicated for injured workers with significant functional deficits or specific complaints of pain located at specific areas of the body. There is an indication the injured worker has complaints of pain at several areas. However, no information was submitted regarding the focus of the requested acupuncture in regards to the specific areas of the body. Additionally, no information was submitted regarding the specific number of sessions being requested as a trial of three sessions is recommended prior to approval of additional sessions. The request for an unknown amount of acupuncture is not medically necessary or appropriate.

#### **ORTHOSTIM 4: Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Transcutaneous electrotherapy Page(s): 114-117.

**Decision rationale:** An Orthostim 4 unit is generally indicated to be used in conjunction with additional therapeutic modalities. No information was submitted regarding the injured worker's ongoing conservative treatments. Therefore, the records do not show that the injured worker would likely benefit from the use of an Orthostim 4 unit. The request for Orthostim 4 is not medically necessary or appropriate.

#### **HOME CARE FOR FOUR HOURS DAILY, THREE DAYS WEEKLY, FOR SIX WEEKS: Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Home health services Page(s): 51.

**Decision rationale:** Home health care is indicated for injured workers who are unable to leave their home with an inadequate support system within the home setting and the injured worker is identified as having significant functional deficits. There is an indication the injured worker is continuing with pain at several areas. However, no information was submitted regarding the injured worker's home setting to include family members within the home. Additionally, it does not appear the injured worker is unable to leave the home without undue stress. The request for home care for four hours daily, three days weekly, for six weeks, is not medically necessary or appropriate.

#### **PSYCHIATRIC RE-EVALUATION: Overturned**

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Psychological evaluations Page(s): 100-101.

**Decision rationale:** The documentation indicates the injured worker continuing with complaints of psychological related complaints. Additionally, the injured worker has been identified as having increased anxiety and fear avoidance. Therefore, it would be reasonable for the injured worker to undergo a reevaluation in order to help guide additional treatments. The request for a psychiatric re-evaluation is medically necessary and appropriate.

**INTERNAL MEDICINE CONSULTATION: Overturned**

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

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Independent Medical Examinations and Consultations Chapter (ACOEM Practice Guidelines, 2nd Edition (2004), Chapter 7), page 503.

**Decision rationale:** The documentation indicates the injured worker utilizing numerous medications to address the ongoing pain complaints. There was also an indication the injured worker's medication regimen is not fully reducing the injured worker's pain levels. Given this factor, it would be reasonable for the injured worker to undergo an internal medicine consultation in order to guide future treatments and provide a pathway to recovery. The request for an internal medicine consultation is medically necessary and appropriate.

**ONE UPDATED SINGLE POSITIONAL MRI OF THE CERVICAL SPINE: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 177-178.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 177-8.

**Decision rationale:** The documentation indicates the injured worker having previously undergone an MRI of the cervical spine. No information was submitted regarding the injured worker's significant changes in the symptomology. Additionally, no information was submitted regarding the injured worker's development of new pathology determined by the most recent clinical exam. The request for one updated single-positional MRI of the cervical spine is not medically necessary or appropriate.

**ONE UPDATED SINGLE POSITIONAL MRI OF THE LUMBAR SPINE: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303-305.

**Decision rationale:** No information was submitted regarding the injured worker's significant changes in the symptomology. Additionally, no information was submitted regarding the injured worker's new development of pathology as determined by the most recent clinical exam. The request for one updated single-positional MRI of the lumbar spine is not medically necessary or appropriate.