MAXIMUS Federal Services

Case Number:	CM13-0022616		
Date Assigned:	11/13/2013	Date of Injury:	05/21/2013
Decision Date:	02/11/2014	UR Denial Date:	08/27/2013
Priority:	Standard	Application Received:	09/10/2013

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 has a subspecialty in Pain Management 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:

This is a female patient of the date of injury of May 21, 2013. A utilization review determination dated August 27, 2013 recommends, non-certification of physical therapy, X force unit, and ice/heat unit. A progress report dated August 7, 2013 indicates that the patient continues to have cervical spine soreness and stiffness, lumbar spine soreness and stiffness, right shoulder pain, and right knee pain rate is 8-10/10. Physical examination findings identify pain with lumbar range of motion, and positive Hoffmans sign. Diagnoses include musculoligamentous cervical and lumbar strain. Treatment plan recommends physical therapy 2X4, X-force unit, and heat/ice unit. A progress report dated July 15, 2013 includes objective findings stating pain with internal rotation and external rotation and abduction of the cervical spine. Reduced range of motion is identified in the cervical spine and shoulders. A progress report dated June 19, 2013 includes a treatment plan stating, "continue additional physical therapy." Multiple physical therapy reports have been included which indicate, "range of motion: improved."

IMR ISSUES, DECISIONS AND RATIONALES

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

Physical Therapy, 8 sessions 2x4, cervical spine, thoracic spine, lumbar spine, right knee, right shoulder: Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): s 173, 200,298, 337-338,Chronic Pain Treatment Guidelines Page(s): 98. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG),Neck &Upper Back Chapter, Physical Therapy, Low back Chapter, Knee & Leg Chapter, Shoulder Chapter

Decision rationale: Regarding the request for additional physical therapy, CA MTUS Guidelines recommend a trial of physical therapy. If the trial of physical therapy results in objective functional improvement, as well as ongoing objective treatment goals, then additional therapy may be considered. Within the documentation available for review, there is no indication of any specific objective functional improvement from the therapy already provided, no documentation of specific ongoing objective treatment goals, and no statement indicating why an independent program of home exercise would be insufficient to address any remaining objective deficits. Additionally, it is unclear exactly how many physical therapy sessions the patient has undergone thus far. In the absence of clarity regarding those issues, the currently requested additional physical therapy is not medically necessary.

X-Force Unit: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation www.wellmark.com/Provider/Med PoliciesAndAuthorizations/MedicalPolicies/Electrical StimulatorsPrinterFriendly.aspx

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): s 114-121. Decision based on Non-MTUS Citation www.sevenseasdm.com/force-stimulator/.

Decision rationale: Regarding the request for X-force stimulation, a search of the Internet indicates that the X-force stimulator is a proprietary device that utilizes a unique electrical signal to deliver monophasic, peaked impulses directly to the joint. Chronic Pain Medical Treatment Guidelines state that electro therapy represents the therapeutic use of electricity and is another modality that can be used in the treatment of pain. Guidelines do not specifically address the currently requested X-force stimulator device. The X-force stimulator website specifically states that this is not a tens unit. A review of the National Library of Medicine reveals no peer-reviewed scientific literature supporting the use of the X-force stimulator. Therefore, in the absence of any peer-reviewed scientific literature supporting the use of the X force stimulator for any of this patient's diagnoses, the currently requested X for stimulator is not medically necessary.

Ice Unit/Heat Unit: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG),TWC Low Back Procedure Summary.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 300. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back Chapter, Cold/Heat Packs.

Decision rationale: Regarding the request for ice unit/heat unit, Occupational Medicine Practice Guidelines recommend the use of physical modalities including heat and ice. They go on to state that at home local applications of heat or cold are as effective as those performed by therapist. ODG echoes the recommendations of Occupational Medicine Practice Guidelines. Guidelines indicate that low-tech modalities for the application of heat and ice are sufficient to address most chronic pain issues, and do not support the need for high-tech therapeutic modalities for the application of heat and ice. As such, the currently requested heat unit/ice unit is not medically necessary.