

Case Number:	CM13-0023263		
Date Assigned:	11/15/2013	Date of Injury:	07/25/1990
Decision Date:	02/28/2014	UR Denial Date:	08/28/2013
Priority:	Standard	Application Received:	09/12/2013

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 and Rehabilitation, has a subspecialty in Interventional Spine 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.

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 69 YO male with a date of injury of 07/25/1990. The listed diagnoses per [REDACTED] 08/21/2013 are: 1. Chronic pain syndrome, 2. Low back pain, 3. Spinal/Lumbar DDD, 4. Post lumbar laminect syndrome, and 5. Lumbar Radiculopathy. According to report dated 08/21/2013 by [REDACTED], patient presents with continued complaints of neck, lower back, bilateral shoulder, left hip, right hip, and feet pain. Patient describes pain as sharp, aching, burning, and shooting. It was noted that patient received trigger point injections in June and July with at least 75% pain relief. Examination of lumbar spine showed healed surgical scar. On palpation, tenderness is noted on both sides of paravertebral muscles and posterior iliac spine. Neurologic examination showed, alert and oriented X3, Cranial nerves are grossly intact. Strength was noted as 5/5 in all major muscle groups. Sensation is intact to light touch and pinprick. Reflexes are equal and symmetric bilaterally in the upper and lower extremities. Babinski is negative, Rhomberh's is negative and Finger to nose coordination is within normal limits. Gait was noted "without ataxia."

IMR ISSUES, DECISIONS AND RATIONALES

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

One (1) rolfing treatment: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Clinical Policy Bulletin: Complementary and Alternative Medicine, Number: 0388.

Decision rationale: This patient presents with continued complaints of neck, lower back, bilateral shoulder, left hip, right hip, and feet pain. Treater requests (1) Rolfing treatment. Rolfing, or structural integration, is one of many types of manipulative therapy. The MTUS, ACOEM nor ODG-TWC guidelines discuss Rolfing specifically. [REDACTED] guidelines do not support Rolfing technique (a structural integration) due lack of evidence. Recommendation is for denial.

one (1) recumbent stationary exercise bike: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Gym Membership.

Decision rationale: This patient presents with continued complaints of neck, lower back, bilateral shoulder, left hip, right hip, and feet pain. Treater requests a stationary bike for "strengthening and reconditioning of lumbar spine." Stationary bikes are not specifically addressed in the MTUS and ACOEM guidelines. However, ODG guidelines state under gym membership, "While an individual exercise program is of course recommended, more elaborate personal care where outcomes are not monitored by a health professional, such as gym memberships or advanced home exercise equipment, may not be covered under this guidelines." "Gym memberships, health clubs, swimming pools, athletic clubs, etc., would not generally be considered medical treatments." Recommendation is for denial.

one (1) hover motorized car: Upheld

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

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

Decision rationale: This patient presents with continued complaints of neck, lower back, bilateral shoulder, left hip, right hip, and feet pain. Treater requests a Hover Motorized wheelchair. For Power Mobility Devices MTUS pg. 99 states, "Not recommended if the functional mobility deficit can be sufficiently resolved by the prescription of a cane or walker, or the patient has sufficient upper extremity function to propel a manual wheelchair, or there is a caregiver who is available, willing, and able to provide assistance with a manual wheelchair. Early exercise, mobilization and independence should be encouraged at all steps of the injury recovery process, and if there is any mobility with canes or other assistive devices, a motorized

scooter is not essential to care." In this case, there does not appear to be any reason why the patient requires a motorized wheelchair. Treater has stated he requests an electric wheel chair "as patient is having extreme difficulty ambulating for his legs are giving out on him." However, report dated 03/26/2013 dates "patient ambulates without a device and gait of the patient is normal." Report dated 07/08/2013 states "patient has slowed gait". Most recent report dated 08/21/2013 states patient has "gait without ataxia" with "5/5 strength in all major muscle groups" and patient is "able to walk with more ease and perform ADLs a little better" with recent TPIs. It is unclear as to why this patient would require a wheel chair as he is currently able to ambulate without any assistive devices. The requested Motorized wheelchair is not medically necessary and recommendation is for denial.

one (1) DRX decompression therapy: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Powered Traction Devices.

Decision rationale: This patient presents with continued complaints of neck, lower back, bilateral shoulder, left hip, right hip, and feet pain. Treater requests DRX decompression therapy. The MTUS and ACOEM do not specifically discuss DRX decompression therapy. Therefore, ODG guidelines are referenced. ODG guidelines under Powered traction devices states, "Not recommended. While there are some limited promising studies, the evidence in support of powered traction devices in general, and specifically vertebral axial decompression, is insufficient to support its use in low back injuries. Vertebral axial decompression for treatment of low back injuries is not recommended. VAX-D therapy may also have risks, including the potential to cause sudden deterioration requiring urgent surgical intervention. Decompression therapy is intended to create negative pressure on the spine, so that the vertebrae are elongated, pressure is taken off the roots of the nerve, and a disk herniation may be pulled back into place. Decompression therapy is generally performed using a specially designed computerized mechanical table that separates in the middle. The above information applies to other brands of powered traction devices as well, including DRX and Lordex." The requested DRX decompression therapy is not medically necessary and recommendation is for denial.

one (1) hot tub for hydrotherapy: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Durable Medical Equipment.

Decision rationale: This patient presents with continued complaints of neck, lower back, bilateral shoulder, left hip, right hip, and feet pain. Treater requests a Hot tub for hydrotherapy "to aide in alleviating back pain." The MTUS, ACOEM and ODG guidelines do not specifically discuss hot tubs. However, ODG guidelines states under "durable medical equipment", an equipment is defined DME if it is primarily and customarily used to serve a medical purpose; generally is not useful to a person in the absence of illness or injury. In this case, a hot tub is generally used by everyone and is not considered a "medical" equipment. The requested "hot tub" is not medically necessary and recommendation is for denial.

one (1) trigger point message therapy: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Massage Therapy Page(s): 60.

Decision rationale: This patient presents with continued complaints of neck, lower back, bilateral shoulder, left hip, right hip, and feet pain. Treater request Trigger Point Massage therapy. Utilization review dated 08/28/2013 denied request stating, "myofascial release is a soft tissue treatment that is not recommended for the treatment of acute, subacute or chronic low back pain." MTUS under its chronic pain section has the following regarding massage therapy: (p60) "Recommended as an option as indicated below. This treatment should be an adjunct to other recommended treatment (e.g. exercise), and it should be limited to 4-6 visits in most cases. Scientific studies show contradictory results. Furthermore, many studies lack long-term follow-up. Massage is beneficial in attenuating diffuse musculoskeletal symptoms, but beneficial effects were registered only during treatment. Massage is a passive intervention and treatment dependence should be avoided. This lack of long-term benefits could be due to the short treatment period or treatments such as these do not address the underlying causes of pain." In this case, a short course of 4-6 visits may be warranted for patient's continued complaints of low back pain. However, treater does not specify the duration or number of visits. The recommendation is for denial of the unspecified number of massage therapy sessions.

One (1) prescription of Carisoprodol 350mg, #60: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle relaxants Page(s): 63.

Decision rationale: This patient presents with continued complaints of neck, lower back, bilateral shoulder, left hip, right hip, and feet pain. Utilization review dated 08/28/2013 modified certification from #60 to #45 for "weaning". Muscle relaxants (for pain) MTUS guidelines p.63. states, "Recommend non-sedating muscle relaxants with caution as a second-line option for short-term treatment of acute exacerbations in patients with chronic LBP. (Chou, 2007) (Mens, 2005) (Van Tulder, 1998) (van Tulder, 2003) (van Tulder, 2006) (Schnitzer, 2004) (See, 2008)

Muscle relaxants may be effective in reducing pain and muscle tension, and increasing mobility. However, in most LBP cases, they show no benefit beyond NSAIDs in pain and overall improvement. Also there is no additional benefit shown in combination with NSAIDs. Efficacy appears to diminish over time, and prolonged use of some medications in this class may lead to dependence." This patient has been taking Carisoprodol since 03/26/2013. Muscle relaxants are not recommended for long term use by MTUS guidelines. The requested Carisoprodol #60 is not medically necessary and recommendation is for denial.