MAXIMUS Federal Services

Case Number:	CM13-0024031		
Date Assigned:	11/20/2013	Date of Injury:	07/08/2011
Decision Date:	02/12/2014	UR Denial Date:	09/10/2013
Priority:	Standard	Application Received:	09/13/2013

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 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. 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 54-year-old female who reported an injury on 07/08/2011. The mechanism of injury was stated to be the patient was carrying a coffee pot weighing approximately 10 pounds and slipped, twisting her back. The patient was noted to have neck, shoulder, and hand pain along with low back pain and numbness and cramping in the lower extremities. The clinical documentation indicated the patient had previous epidurals that helped. The patient was noted to have a prior carpal tunnel release. It was indicated the patient had a previous EMG/NCS on 07/10/2012, which revealed bilateral entrapment neuropathy of the median nerves. The patient's diagnoses were noted to include cervical disc degeneration, cervical radiculitis, lumbar disc degeneration, lumbar radiculitis, and bilateral carpal tunnel, as well as myalgias. The plan was noted to include physical therapy for carpal tunnel syndrome 2 times a week for 8 weeks, an H-Wave unit, physical therapy for the lumbar and cervical spine, an orthopedic referral, and a right subacromial injection.

IMR ISSUES, DECISIONS AND RATIONALES

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

Physical Therapy 2x8, Bilateral wrists: Upheld

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

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

Decision rationale: CA MTUS states that physical medicine with passive therapy can provide short term relief during the early phases of pain treatment and are directed at controlling symptoms such as pain, inflammation and swelling and to improve the rate of healing soft tissue injuries. Treatment is recommended with a maximum of 9-10 visits for myalgia and myositis. The clinical documentation submitted for review indicated the patient had previous physical therapy. However, it failed to indicate the number of sessions the patient had previously as the patient was noted to have a prior carpal tunnel release. It was noted as of 03/19/2013, the patient had completed physical therapy for bilateral carpal tunnel. Given the above and the lack of documentation of functional improvement, the request for Physical Therapy 2x8, Bilateral wrists is not medically necessary.

Home E-Stim/H-wave unit (purchase): Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines H-wave Page(s): 117.

Decision rationale: California MTUS guidelines do not recommend H-wave stimulation as an isolated intervention, however, recommend a one-month trial for neuropathic pain or chronic soft tissue inflammation if used as an adjunct to a program of evidence based restoration and only following failure of initially recommended conservative care, including recommended physical therapy (i.e.,exercise) and medications, plus transcutaneous electrical nerve stimulation (TENS). The clinical documentation submitted for review indicated the patient failed initially recommended conservative care including physical therapy and medications; however, there is a lack of documentation indicating the patient failed transcutaneous electrical nerve stimulation. Additionally, there is a lack of documentation indicating the necessity for purchase of the unit without trialing the unit. Given the above, the request for Home E-Stim/H-wave unit (purchase) is not medically necessary.

Physical Therapy 2-3x4-6 for Cervical and Lumbar Spine: Upheld

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

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

Decision rationale: CA MTUS states that physical medicine with passive therapy can provide short term relief during the early phases of pain treatment and are directed at controlling symptoms such as pain, inflammation and swelling and to improve the rate of healing soft tissue injuries. Treatment is recommended with a maximum of 9-10 visits for myalgia and myositis.

The clinical documentation submitted for review indicated the patient had previously undergone physical therapy. However, there was a lack of documentation of the patient's functional response to physical therapy. Additionally, there was a lack of documentation indicating the number of sessions the patient had participated in. Additionally, the request would exceed recommended Guidelines and the patient should be well versed in a home exercise program. Given the above, the request for Physical Therapy 2 3x4-6 for Cervical and Lumbar Spine is not medically necessary.

Right Shoulder Ortho Surgery Consult: Overturned

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 209-210.

Decision rationale: ACOEM Guidelines recommend a surgical consultation may be indicated for patients who have red flag conditions, activity limitations for more than 4 months plus the existence of a surgical lesion, failure to increase range of motion and strength of musculature around the shoulder even after exercise programs plus the existence of a surgical lesion, and clear and clinical imaging evidence of a lesion that has been shown to benefit in both the short and long term from surgical repair. The patient was noted to have an MRI of the right shoulder without contrast on 05/14/2013, which revealed a low grade partial thickness tear of the junctional fibers of the supraspinatus and infraspinatus tendons seen on a background of tendinopathy and degenerative changes of acromioclavicular joint as well as a 13 x 8 x 5 mm multilobulated cystic lesion in the region of the suprascapular notch which may represent a ganglion cyst versus a venous varix. There was no evidence of denervation edema involving the supraspinatus or infraspinatus musculature. Physical examination revealed the patient had a positive Hoffmann's bilaterally, positive Spurling's bilaterally, positive Tinel's on the left, positive Hawkins on the right shoulder, and Yergason's. It was indicated the patient had an EMG/NCS on 07/10/2012, which revealed bilateral entrapment neuropathy of the median nerves. The clinical documentation submitted for review indicated the patient failed all conservative measures including anti-inflammatories, analgesics, pain medication, physical therapy, and rest. As such, the request for a Right Shoulder Ortho Surgery Consult is medically necessary.

Right Subacromial Injection: Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 213.

Decision rationale: ACOEM Guidelines recommend 2 or 3 subacromial injections of local anesthetic and cortisone to treat rotator cuffs as part of an exercise rehabilitation program. The clinical documentation submitted for review failed to provide the patient was undergoing an

exercise rehabilitation program. It failed to provide documentation of the necessity for the request. Given the above, the request for Right Subacromial injection is not medically necessary.

ESI, C4-5, C5-6: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Epidural Steroid Injection Page(s): 46.

Decision rationale: California MTUS guidelines recommend for repeat Epidural steroid injection, there must be objective documented pain and functional improvement, including at least 50% pain relief with associated reduction of medication use for six to eight weeks, with a general recommendation of no more than 4 blocks per region per year. The clinical documentation submitted for review indicated the patient had a previous epidural steroid injection; however, there was a lack of documentation of the location of the epidural steroid injection. Additionally, there was a lack of objective documented pain and functional improvement including at least 50% relief with associated reduction of medication use for 6 to 8 weeks. Given the above, the request for ESI, C4-5, C5-6 is not medically necessary.

Transforminal ESI, L4-5, L5-S1, left PT 2x8 bilateral wrist: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Epidural Steroid Injection,Physical Medicine Page(s): 46,98-99.

Decision rationale: California MTUS guidelines recommend for repeat Epidural steroid injection, there must be objective documented pain and functional improvement, including at least 50% pain relief with associated reduction of medication use for six to eight weeks, with a general recommendation of no more than 4 blocks per region per year. The clinical documentation submitted for review indicated the patient had a previous epidural steroid injection; however, there was a lack of documentation of the location of the epidural steroid injection. Additionally, there was a lack of objective documented pain and functional improvement including at least 50% relief with associated reduction of medication use for 6 to 8 weeks. The request for physical therapy for the bilateral wrists is addressed in request # 2 and is therefore, not medically necessary. Given the above, the request for Transforaminal ESI, L4-5, L5-S1, left PT/2x8, bilateral wrist is not medically necessary.

Right Subacromial Injection under claim #13456: Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 213.

Decision rationale: This request is a duplicate of request number 3. As such, the request is not medically necessary.