

Case Number:	CM13-0032004		
Date Assigned:	03/28/2014	Date of Injury:	07/24/1997
Decision Date:	04/30/2014	UR Denial Date:	09/16/2013
Priority:	Standard	Application Received:	10/04/2013

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 Orthopedic Surgery, has a subspecialty in Spine Surgery and is licensed to practice in Texas and 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 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 patient is a 67-year-old male who reported an injury on 07/24/1997. The mechanism of injury was not provided for review. The patient was evaluated on 09/11/2013. It was documented that the patient's chronic low back pain was managed with medications. It was also noted that the patient had recently had a blackout spell, which caused a fall. The patient complained at that time of increased left shoulder, left hip, neck, and back pain with increased headaches. The patient's physical findings included limited cervical, lumbar, and leg range of motion with a positive straight leg raising test bilaterally and decreased deep tendon reflexes bilaterally. The patient's diagnoses included cephalgia, dizziness, imbalance, and instability, cervical radiculopathy, lumbar radiculopathy, interscapular pain, coccydynia, seizure disorder, cognitive impairment, emotional distress, and sleep impairment. The patient's treatment plan included a brain MRI, continuation of medications, referral to a dentist, a CT of the chest, an abdominal MRI, an electrocardiogram, a lift chair, aquatic therapy, acupuncture, topical analgesics, and nonsurgical decompression.

IMR ISSUES, DECISIONS AND RATIONALES

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

LUMBAR DECOMPRESSION (NON SURGICAL): 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), IDD Therapy (Intervertebral Disc Decompression).

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation OFFICIAL DISABILITY GUIDELINES (ODG) LOW BACK CHAPTER, IDD THERAPY (INTERVERTEBRAL DISC DECOMPRESSION)

Decision rationale: The requested lumbar decompression (non-surgical) is not medically necessary or appropriate. The California Medical Treatment and Utilization Schedule does not address this type of treatment. The Official Disability Guidelines do not support the use of intervertebral disc decompression, as there is little scientific evidence to support the efficacy and safety of this treatment modality. The clinical documentation submitted for review does not provide any evidence to support extending treatment beyond Guideline recommendations. As such, the requested lumbar decompression (non-surgical) is not medically necessary or appropriate.

FUNCTIONAL CAPACITY EVALUATION: Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 5 Cornerstones of Disability Prevention and Management Page(s): 89-92.

Decision rationale: The requested functional capacity evaluation is not medically necessary or appropriate. The American College of Occupational and Environmental Medicine recommends Functional Capacity Evaluations when a more precise delineation of the patient's capabilities to perform job duties is needed beyond what can be provided by normal physical examination. The clinical documentation submitted for review does not provide any evidence that the patient is at or near maximum medical improvement and intends to return to work. Therefore, the need to evaluate the patient's physical capabilities to determine his ability to perform work duties is not clearly indicated. Additionally, it is noted that the patient is retired. There is no documentation that the patient intends to return to work to support the need for this type of evaluation. As such, the requested functional capacity evaluation is not medically necessary or appropriate.

CHAIR WITH ASSISTED LIFTING: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ACOEM, Chapter 7: Independent Medical Examinations and Consultations, page 127.

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

Decision rationale: The requested chair with assisted lifting is not medically necessary or appropriate. The California Medical Treatment and Utilization Schedule does not address durable medical equipment. The Official Disability Guidelines recommend durable medical

equipment as a rental option when the equipment is needed and is not useful to the patient in the absence of injury or illness and can assist the patient within the home. The clinical documentation does indicate that the patient has significant lumbar pain that could interfere with the patient's ability to stand without assistance. However, the clinical documentation does not provide any evidence that the patient does not have a caregiver in the home that can assist with standing from a seated position. Additionally, the request as it is written does not clearly identify whether this equipment is for rental or purchase. Therefore, the appropriateness of the request itself cannot be determined. As such, the requested chair with assisted lifting is not medically necessary or appropriate.

CT SCAN OF THE CHEST: 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), Low Back/Thoracic Chapter, CT (Computed Tomography)

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pulmonary Chapter, CT (Computed Tomography)

Decision rationale: The requested CT scan of the chest is not medically necessary or appropriate. The California Medical Treatment and Utilization Schedule does not address this type of treatment. The Official Disability Guidelines recommend CT scans of the chest for patients who are suspected of lung diseases or respiratory complications. The clinical documentation submitted for review does indicate that the patient has experienced a blackout, which caused a fall. However, the patient's physical exam findings were within normal limits and does not support the need for this type of imaging study. As such, the requested CT scan of the chest is not medically necessary or appropriate

MRI OF THE ABDOMEN: 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), Hip and Pelvis Chapter, MRI (Magnetic Resonance Imaging)

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation American College of Radiology, Practice Guidelines For The Magnetic Resonance Imaging of The Abdomen (Excluding The Liver), RES 16-2010.

Decision rationale: The requested MRI of the abdomen is not medically necessary or appropriate. The California Medical Treatment and Utilization Schedule and Official Disability Guidelines do not specifically address this treatment. The American College of Radiology Practice Guidelines for MRIs of the Abdomen indicate that this imaging study is appropriate when there are red flag conditions that are supported by physical findings. The clinical documentation submitted for review does indicate that the patient had a blackout, which caused a fall. However, the patient's physical findings do not support any red flag conditions that would

require an MRI of the abdomen. As such, the requested MRI of the abdomen is not medically necessary or appropriate.

ACUPUNCTURE 3 X PER WEEK FOR 4 WEEKS: Upheld

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

MAXIMUS guideline: Decision based on MTUS Acupuncture Treatment Guidelines.

Decision rationale: The requested acupuncture 3 times per week for 4 weeks is not medically necessary or appropriate. The California Medical Treatment and Utilization Schedule recommends ongoing acupuncture for patients who have documentation of functional benefit and symptom relief. The clinical documentation does indicate that the patient previously had acupuncture. However, the number of treatments the patient has already had was not addressed. Therefore, a trial of acupuncture may be appropriate for this patient. However, the requested 12 treatments exceed the recommendation of a 6-visit trial. There are no exceptional factors noted within the documentation to support extending treatment beyond Guideline recommendations. Additionally, the request does not specify a body part that the acupuncture would be applied to; therefore, the appropriateness of the request itself cannot be determined. As such, the requested acupuncture 3 times per week for 4 weeks is not medically necessary or appropriate.

AQUATIC THERAPY 3 X PER WEEK FOR 4 WEEKS: Upheld

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

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

Decision rationale: The requested aquatic therapy 3 times per week for 4 weeks is not medically necessary or appropriate. The California Medical Treatment and Utilization Schedule recommends aquatic therapy for patients who require a non-weight bearing environment while participating in active therapy. The clinical documentation submitted for review does not provide any evidence that the patient cannot participate in land based therapy and requires a non-weight bearing environment. Therefore, the need for aquatic therapy is not clearly established. Additionally, the California Medical Treatment and Utilization Schedule recommends up to 8 to 10 visits for this type of injury. The requested 12 visits exceed this recommendation. There are no exceptional factors noted within the documentation to support extending treatment beyond Guideline recommendations. Additionally, the aquatic therapy request does not include a body part. Therefore, the appropriateness of the request itself cannot be determined. As such, the requested aquatic therapy 3 times per week for 4 weeks is not medically necessary or appropriate.