

Case Number:	CM13-0038148		
Date Assigned:	01/03/2014	Date of Injury:	04/15/2002
Decision Date:	03/19/2014	UR Denial Date:	09/17/2013
Priority:	Standard	Application Received:	09/27/2013

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 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:

The patient is a 60 year old female with a date of injury of 4/15/12. The actual mechanism of injury is not included in the submitted reports. The patient is under the care of a neurosurgical specialist for multiple diagnoses, including bilateral upper extremity RSD, left upper extremity dystonia, lumbar radiculopathy, s/p cervical fusion, and s/p SCS implantation that is partially removed. According to the 9/17/13 Utilization Review report, the accepted body parts/diagnoses include the back, neck, teeth, upper/lower extremities and internal organs. The patient returned in follow-up on 9/11/13 with ongoing pain issues, however, there has been an increase in lumbar pain and the development of severe right hip pain. Bilateral shoulder pain has also increased. Headaches are worse. Exam on that date shows involuntary tonic-clonic movements, rotation/tilting of the head to the left, arm/neck elevation, dysesthesias-allodynia-hyperpathia at the left arm, left arm coolness, and tenderness at the right hip and pelvis. Recommendation is made for "continued" acupuncture, physiotherapy, aqua therapy and medications. 9/17/13 UR report did not recommend certification of any of the treatments.

IMR ISSUES, DECISIONS AND RATIONALES

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

Outpatient aquatic therapy three (3) times a week times four (4) weeks to multiply body parts: 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: Guidelines do support aquatic therapy as an optional form of exercise therapy, it is specifically recommended when reduced weight bearing is desirable. In this case, reducing the effects of gravity while promoting exercise would certainly be of benefit, given the severe hip pain and increased lumbar pain. However, the report requesting aquatic therapy is asking for "continued" aqua therapy. The total amount of sessions completed to date are not disclosed, and it is unclear if what has been done has resulted in any progress. In fact, if the patient is having "increased" pain, and they currently are in aquatic therapy, it certainly seems like the treatment may even be making the patient feel worse. Without clear discussion of treatment to date with regards to this request for "continued" aquatic therapy, including number of sessions and progress in treatment, medical necessity for this treatment is not established.

Interferential unit (IF): Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Transcutaneous Electrotherapy/Interferential Current Stimulation Page(s): s 118-119.

Decision rationale: Interferential Stimulation units are not recommended as an isolated intervention, but may be appropriate for a trial (defined as 1-month), if the pain is ineffectively controlled by meds due to side effects or diminished effectiveness, if there is a history of substance abuse, if the patient is unresponsive to conservative measures, or the patient has significant post-op pain and is limited in the ability to perform PT/exercise. In this case, the requesting provider does not provide any clinical details that meet these guideline criteria. In addition, the request does not include a specific duration, so I would assume the request is for a purchase. A trial would be the first appropriate step prior to considering a purchase. Medical necessity for this device is not established.

Physical therapy: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines CRPS Page(s): s 35-41. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back, Shoulder, Hip & Pelvis, Pain; Physical therapy, CRPS

Decision rationale: Guidelines do support PT for all the body parts and diagnoses involved. However, the report requesting physical therapy is asking for "continued" physical therapy. The total amount of sessions completed to date are not disclosed, and it is unclear if what has been done has resulted in any progress. In fact, if the patient is having "increased" pain, and they

currently are in physical therapy, it certainly seems like the treatment may even be making the patient feel worse. Finally, this request does not ask for a specific number of PT sessions. Without clear discussion of treatment to date with regards to this request for "continued" physical therapy, including number of sessions and progress in treatment, medical necessity for this treatment is not established.

Right shoulder injections: Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): s 211-214. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Shoulder, Steroid injections

Decision rationale: Guidelines support specific types of injection for specific conditions that are supported by the clinical symptoms and objective exam findings. In this case, The 9/11/13 report states that the patient is having increased pain at the shoulders. However, there is no shoulder exam, there is no shoulder diagnosis, and there is no discussion of what kind of shoulder injection is to be done. Following the Utilization Review denial on 9/17/13, the 11/19/13 follow-up report does not even discuss shoulder injections again. Without clinical details with regards to actual shoulder exam abnormalities, suspected clinical diagnosis, and type of shoulder injection to be given, medical necessity is not established.