

Case Number:	CM13-0039784		
Date Assigned:	12/20/2013	Date of Injury:	01/01/1988
Decision Date:	02/19/2014	UR Denial Date:	10/03/2013
Priority:	Standard	Application Received:	10/08/2013

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 Anesthesiology and Pain Medicine and is licensed to practice in Florida. 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 47-year-old female who reported an injury on 01/01/1988 due to a slip and fall. Previous treatments included a lumbar support and medications. The patient continued to complain of constant low back pain, constant right shoulder pain radiating into the neck, and bilateral lower extremity pain. The patient's most recent clinical examination findings included tenderness to palpation over the C2 through C7 and L1 through L5 paraspinal musculature, right shoulder impingement with 80 degrees of abduction and a positive bilateral Kemp's test and a positive bilateral straight leg raising test. The patient's diagnoses included cervical spine sprain/strain, thoracic spine sprain/strain, lumbar spine sprain/strain, lumbar spine radiculopathy, right upper extremity sprain, right shoulder impingement, right lateral elbow epicondylitis. The patient's treatment plan included acupuncture, physical therapy, a continuous flow cryotherapy machine, and a cervical orthopedic pillow.

IMR ISSUES, DECISIONS AND RATIONALES

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

Physical therapy for the neck, back, right shoulder and feet (8 sessions): Upheld

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

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

Decision rationale: The requested physical therapy for the neck, back, right shoulder and feet is not medically necessary or appropriate. The clinical documentation submitted for review does not provide evidence that the patient has participated in physical therapy. The efficacy of that therapy is not established within the documentation. California Medical Treatment Utilization Schedule recommends continued therapy be based on objective functional gains. Additionally, California Medical Treatment Utilization Schedule states that patients should be transitioned into a home exercise program to maintain functional levels obtained during skilled physical therapy. The clinical documentation submitted for review does not provide any evidence that the patient is participating in a home exercise program. Although a short course of treatment may be indicated to re-establish a home exercise program, the requested eight sessions is considered excessive. As such, the requested physical therapy is not medically necessary or appropriate.

Acupuncture for the neck, back, right shoulder and feet (8 sessions): 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 for the neck, back, right shoulder and feet is not medically necessary or appropriate. The clinical documentation submitted for review does not provide evidence that the patient previously participated in acupuncture. California Medical Treatment Utilization Schedule recommends continuation of acupuncture therapy be based on significant functional gains and symptom improvement. The clinical documentation submitted for review does not provide any evidence of significant functional gains as a result of prior therapy. Therefore, continuation of this type of therapy would not be supported. As such, the requested acupuncture for the neck, back, right shoulder and feet 2x4 is not medically necessary or appropriate.

heat/cool contrast machine or heating pad: 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), Shoulder and Knee & Leg Chapters, Continuous Flow Cryotherapy.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 177-179. Decision based on Non-MTUS Citation ODG, Neck and Upper Back Chapter.

Decision rationale: The requested heat/cold contrast machine or heating pad is not medically necessary or appropriate. The American College of Occupational and Environmental Medicine do recommend the alternation of heat and cold packs to assist with pain control for low back pain. However, the clinical documentation submitted for review does not provide any evidence that the patient has failed to respond to self managed therapy. Additionally, a cryotherapy unit is not indicated in the absence of surgical intervention. The clinical documentation submitted for

review does not provide evidence that the patient has undergone surgical intervention that would benefit from this type of therapy. As there is no documentation that the patient has failed to respond to self managed hot/cold pack therapy and there is no documentation of any recent surgical intervention, the requested treatments would not be indicated. As such, the requested heat/cold contrast machine or heating pad is not medically necessary or appropriate.

cervical orthopedic pillow: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG, Cervical Spine.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG, Neck and Upper Back Chapter.

Decision rationale: The requested cervical orthopedic pillow is not medically necessary or appropriate. The clinical documentation submitted for review does provide evidence that the patient has chronic neck pain. Official Disability Guidelines recommend a cervical pillow for support during sleep in conjunction with an active therapy program. The clinical documentation submitted for review does not provide any evidence that the patient is currently participating in an active therapy program such as a home exercise program. Therefore, the addition of a cervical orthopedic pillow would not provide any functional benefit. As such, the requested cervical orthopedic pillow is not medically necessary or appropriate.