MAXIMUS Federal Services

Case Number:	CM13-0042142		
Date Assigned:	12/27/2013	Date of Injury:	05/28/2013
Decision Date:	02/28/2014	UR Denial Date:	10/07/2013
Priority:	Standard	Application Received:	10/15/2013

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 & 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. 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 57 year old male with a date of injury of 05/28/2013. The listed diagnoses per [redacted] dated 08/14/2013 are: 1. Cervical musculoligamentous sprain/strain with left upper extremity radiculitis 2. Left shoulder periscapular myofascial strain 3. Lumbosacral musculoligamentous sprain/strain and left sacroiliac joint dysfunction with left lower extremity radiculitis 4. Left knee sprain and patellofemoral arthralgia 5. Left foot dorsiflexon tenosynovitis 6. Complaints of sleep difficulties secondary to chronic pain and limitation/impairment According to report dated 08/14/2013 by [redacted], patient presents with neck, lower back, left shoulder, left knee, and left foot pain. Patient also complains of sleep disturbances and reports waking up one to two times per night, resulting in daytime drowsiness. Examination of the left shoulder reveals tenderness to palpation with hypertonicity over periscapular muscle, upper trapezius muscle, levator scapular and over the rhomboid musculature. Decreased ROM was noted. Examination of the lumbar spine reveals pelvic unleveling with left innominate displaced inferiorly. Tenderness to palpation with hypertonicity muscle guarding is present. Straight leg raise is negative bilaterally; however, left sided testing elicits increased localized lower back pain. Examination of the left ankle/foot reveals pes plantus and slight valgus deformities. Tenderness to palpation is present over the dorsiflexor tendons for the foot with increased pain upon resistance. It is noted that patient "is not working having last worked on 05/28/2013".

IMR ISSUES, DECISIONS AND RATIONALES

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

Sleep consult/study between 9/24/2013 and 11/23/2013: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints, Chapter 9 Shoulder Complaints, Chapter 12 Low Back Complaints, Chapter 13 Knee Complaints, Chapter 14 Ankle and Foot Complaints Page(s): 167, 173 AND 300, 203- 205, 298-299, 339, 369,Acupuncture Treatment Guidelines,Chronic Pain Treatment Guidelines.

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

Decision rationale: This patient presents with neck, lower back, left shoulder, left knee, and left foot pain. Treater requests a consultation with a sleep specialist to address patient's complaints of sleep difficulties. It was noted patient has interrupted sleep as he wakes up one to two times per night totaling five to six hours of sleep. MTUS and ACOEM guidelines do not address sleep studies however ODG guidelines has the following regarding polysomnogram, "Recommended after at least six months of an insomnia complaint (at least four nights a week), unresponsive to behavior intervention and sedative/sleep-promoting medications, and after psychiatric etiology has been excluded." In this case, the treater has not discussed behavior intervention, does not list what medications have been tried, and psychiatric etiology has not been excluded yet. The treater also does not describe any morning time headaches due to insomnia, personality change and although daytime drowsiness is described, it is not documented as "excessive daytime somnolence." Recommendation is for denial.

OrthoStim 4 and Thermophore units between 9/24/2013 and 11/23/2013: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints, Chapter 9 Shoulder Complaints, Chapter 12 Low Back Complaints, Chapter 13 Knee Complaints, Chapter 14 Ankle and Foot Complaints Page(s): 167, 173 AND 300, 203- 205, 298-299, 339, 369,Acupuncture Treatment Guidelines,Chronic Pain Treatment Guidelines.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 117 AND 121.

Decision rationale: This patient presents with neck, lower back, left shoulder, left knee, and left foot pain. Treater requests OrthoStim and Thermaphone units "for home use to better manage the patient's pain/symptoms". OrthoStim is a neuromuscular electrical stimulation. The MTUS guidelines under NMES devices p121 states, "Not recommended. NMES is used primarily as part of a rehabilitation program following stroke and there is no evidence to support its use in chronic pain. There are no intervention trials suggesting benefit from NMES for chronic pain." Thermaphone unit is a galvanic stimulation unit. MTUS guidelines under galvanic stimulation (page 117) states, "Not recommended. Electroceutical therapy (also known as bioelectric nerve block) is experimental and investigational for the treatment of chronic pain (e.g., back pain, diabetic pain, joint pain, fibromyalgia, headache, and CRPS) because there is a lack of scientific

evidence regarding the effectiveness of this technology. In addition, electroceutical treatments use much higher electrical frequencies than TENS units and may only be prescribed and administered under the supervision of a healthcare provider experienced in this method of treatment." The OrthoStim is intended for stroke patients and the Thermaphone is considered experimental and investigational. In this case, both units are not medically necessary and recommendation if for denial.

Eight chiropractic treatments between 9/24/2013 and 11/23/2031: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints, Chapter 9 Shoulder Complaints, Chapter 12 Low Back Complaints, Chapter 13 Knee Complaints, Chapter 14 Ankle and Foot Complaints Page(s): 167, 173 AND 300, 203- 205, 298-299, 339, 369,Acupuncture Treatment Guidelines,Chronic Pain Treatment Guidelines.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines.

Decision rationale: This patient presents with neck, lower back, left shoulder, left knee, and left foot pain. Treater requests 8 chiropractic visits "for spinal manipulation and rehabilitative exercises." Medical records indicate patient was authorized 4 chiropractic visits on 09/02/2012 with no noted benefits. For Chiropractic treatments, MTUS guidelines recommends as an option trial of 6 visits over 6-8 weeks. For recurrences/flare-ups re-evaluate treatment success and if RTW is achieved then 1-2 visits every 4-6 months. In this case, the treater indicates patient "is not working having last worked on 05/28/2013". Furthermore, for flare-up's and if return to work is achieved; only 1-2 sessions every 4-6 months are recommended. The treater's current request for 8 visits exceeds what is allowed by MTUS guidelines. Recommendation is for denial.