

Case Number:	CM13-0055280		
Date Assigned:	12/30/2013	Date of Injury:	09/12/2013
Decision Date:	05/23/2014	UR Denial Date:	10/29/2013
Priority:	Standard	Application Received:	11/20/2013

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 Physical Medicine & Rehabilitation and is licensed to practice in Minnesota. 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 injured worker is a 39-year-old male who reported an injury on 09/12/2013 after he lifted a heavy alignment jack and reportedly sustained an injury to his back and left shoulder. The injured worker was evaluated on 11/19/2013. It was documented that the injured worker had continued bilateral shoulder pain, cervical spine pain, lumbar spine pain, thoracic spine pain, ribcage pain, and testicle pain. It was exacerbated by lifting. Physical findings included +3 tenderness to palpation of the paraspinal musculature from the C3 to the C7, a positive axial compression test, and positive shoulder depression test bilaterally. It was documented that the injured worker had decreased right triceps reflexes and +3 spasming and tenderness to the right rhomboid and paraspinal musculature between T2 through T9, a positive Schepplemann's test. Evaluation of the lumbar spine documented +4 spasming and tenderness in the bilateral lumbar paraspinal musculature from the L2 through the S1 with limited range of motion secondary to pain, a positive Kemp's test bilaterally, and a positive straight leg raising test bilaterally. It was noted that the injured worker had decreased sensation in the L5 and S1 dermatomes on the right side. Evaluation of the shoulders documented +3 spasming and tenderness of the bilateral upper shoulder muscles and bilateral rotator cuff muscles with a positive Codman's test bilaterally, a positive Speed's test bilaterally, and a positive supraspinatus test bilaterally. The injured worker's diagnoses included cervical disc herniation with myelopathy, thoracic disc displacement with myelopathy, lumbar disc displacement with myelopathy, sciatica, bursitis and tendonitis of the bilateral shoulders and a partial tear of the rotator cuff tendon of the bilateral shoulders. The injured worker's treatment plan included physical therapy and medications. A request was made for an x-ray of the ribs, x-ray of the lumbar spine, EMG/NCV of the bilateral upper extremities, EMG/NCV of the bilateral lower extremities, and a multi-interferential stimulation unit, followed by a qualified Functional Capacity Evaluation.

IMR ISSUES, DECISIONS AND RATIONALES

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

X-RAY OF THE RIBS, AXILLARY LINE AND BILATERAL: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation ACR-SPR Practice Guideline for the Performance of Chest Radiography, res. 56-2011.

Decision rationale: The American College of Radiology states that chest x-rays are useful for evaluating the chest wall due to persistent pain. The clinical documentation submitted for review does indicate that the injured worker has complaints of moderate pain exacerbated by sideways movements. However, an evaluation of the injured worker's chest was not provided to determine the need for further diagnostic studies. No documentation of chest abnormalities or suspicion of traumatic injury was provided. As such, the requested x-ray of the ribs, axillary line and bilateral, is not medically necessary and appropriate.

X-RAY OF LUMBAR SPINE: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Page(s): 308-310.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303-305.

Decision rationale: The ACOEM Guidelines does not recommend x-rays of the lumbar spine in the absence of red flags or serious spinal pathology. However, lumbar x-rays may be appropriate when the treating physician believes it would aid in patient management. The clinical documentation submitted for review does not provide any evidence of suspicion of red flag conditions or other serious spinal pathology other than persistent pain. The clinical documentation does not provide any evidence of justification of how this study would contribute to the injured worker's treatment planning. As such, the requested lumbar x-rays are not medically necessary or appropriate.

EMG OF THE BILATERAL UPPER EXTREMITIES: 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) Neck and Upper Back.

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

Decision rationale: The ACOEM Guidelines does not recommend electrodiagnostic studies until the injured worker had failed a period of observation and conservative treatment. The clinical documentation indicates that the injured worker is still undergoing conservative treatments. Therefore, further electrodiagnostic studies would need to be determined after the outcome of that treatment. As such, the requested EMG of the bilateral upper extremities is not medically necessary and appropriate.

EMG OF THE BILATERAL LOWER EXPREMITIES: 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.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303-305.

Decision rationale: The ACOEM Guidelines does not recommend electrodiagnostic studies until the injured worker had failed a period of observation and conservative treatment. The clinical documentation indicates that the injured worker is still undergoing conservative treatments. Therefore, further electrodiagnostic studies would need to be determined after the outcome of that treatment. As such, the requested EMG of the bilateral lower extremities is not medically necessary or appropriate.

MULTI-INFERENTIAL STIMULATOR UNIT FOR A 90 DAY RENTAL: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines section on Interferential Current Stimulation Page(s): 118. Decision based on Non-MTUS Citation MTUS: CHRONIC PAIN MEDICAL TREATMENT GUIDELINES PHYSICAL MEDICINE, , 118

Decision rationale: The MTUS Chronic Pain Guidelines recommends interferential current stimulation for injured workers who have failed all other first-line chronic pain management treatments to include physical therapy, medications, and a TENS unit. There is no documentation that the injured worker has failed to respond to a TENS unit. Additionally, the request is for a 90-day rental. The MTUS Chronic Pain Guidelines recommends a trial of 30 days to assess the efficacy of this treatment intervention. There is no documentation that the injured worker has already undergone a trial that would support a 90-day rental of this medical equipment. As such, the requested multi-interferential stimulation unit for a 90-day rental is not medically necessary and appropriate.

QUALIFIED FUNCTIONAL CAPACITY EVALUATION: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG Fitness for Duty

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

Decision rationale: The ACOEM Guidelines recommends functional capacity evaluations when a more precise delineation of the injured worker's functional capabilities is required beyond what can be determined during a traditional examination. The clinical documentation submitted for review does not support the need for a more focused examination than what could be provided by the treating physician. There is no documentation that the injured worker is at or even near maximum medical improvement. There is no documentation to support that the injured worker is a candidate for a work hardening or chronic pain management program. Therefore, the need for a qualified Functional Capacity Evaluation cannot be determined. As such, the requested qualified Functional Capacity Evaluation is not medically necessary and appropriate.

NCV OF THE BILATERAL UPPER EXTREMITIES: 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) Neck And Upper Back.

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

Decision rationale: The ACOEM Guidelines does not recommend electrodiagnostic studies until the injured worker had failed a period of observation and conservative treatment. The clinical documentation indicates that the injured worker is still undergoing conservative treatments. Therefore, further electrodiagnostic studies would need to be determined after the outcome of that treatment. As such, the requested NCV of the bilateral upper extremities is not medically necessary or appropriate.

NCV OF THE BILATERAL LOWER EXTREMITIES: 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.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303-305.

Decision rationale: The ACOEM Guidelines does not recommend electrodiagnostic studies until the injured worker had failed a period of observation and conservative treatment. The clinical documentation indicates that the injured worker is still undergoing conservative treatments. Therefore, further electrodiagnostic studies would need to be determined after the outcome of that treatment. As such, the requested NCV of the bilateral lower extremities is not medically necessary and appropriate.

PROGRAM FOR PHYSICAL MEDICINE FOR 12 VISITS TO INCLUDE ELECTRICAL MUSCLE STIMULATION TO THE BILATERAL SHOULDERS, INFRARED TO THE CERVICAL AND LUMBAR SPINE; CHIROPRACTIC MANIPULATION TO THE CERVICAL, THORACIC, AND LUMBAR SPINE; MYOFASCIAL RELEASE TO THE CERVICAL SPINE, BILATERAL SHOULDER, AND LUMBAR: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Page(s): 298-301.
Decision based on Non-MTUS Citation ODG Low Back, Shoulder.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Page(s): 98-99, 58-60.

Decision rationale: The MTUS Chronic Pain Guidelines recommends up to 8 to 10 visits of physical therapy for myofascial and radicular pain. The clinical documentation does indicate that the injured worker has already participated in some physical therapy. That therapy in combination with the requested 12 visits would exceed MTUS Chronic Pain Guidelines' recommendations. Although a period of physical therapy may be indicated for this patient, there are no exceptional factors noted to extend treatment so far beyond MTUS Guidelines' recommendations. Additionally, the clinical documentation lacks any evidence that the injured worker has previously participated in chiropractic care. The MTUS Chronic Pain Guidelines recommends a trial of 6 visits of chiropractic care to establish the efficacy of this type of treatment. The request exceeds that recommendation. There are no exceptional factors noted within the documentation to support extending treatment beyond guideline recommendations. Regarding the myofascial release portion of the request, the MTUS Chronic Pain Guidelines recommends up to 4 to 6 visits of massage therapy as appropriate treatment. However, there is no efficacy of treatment beyond 4 to 6 visits. The requested 12 visits exceed this recommendation. As such, the request of a program for physical medicine for 12 visits to include electrical muscle stimulation to the bilateral shoulders, infrared to the cervical and lumbar spine; chiropractic manipulation to the cervical, thoracic and lumbar spine; myofascial release to the cervical spine, bilateral shoulder, and lumbar spine, and therapeutic activities is not medically necessary and appropriate.