MAXIMUS Federal Services

Case Number:	CM13-0057370		
Date Assigned:	12/30/2013	Date of Injury:	10/26/2007
Decision Date:	04/10/2014	UR Denial Date:	11/20/2013
Priority:	Standard	Application Received:	11/25/2013

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 and Rehabilitation and is licensed to practice in Illinois. 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 53-year-old male who reported an injury on 10/26/2007. The mechanism of injury was not provided. The orthopedic examination dated 11/01/2013 indicated the patient reported he had much improvement to the right shoulder. The patient reported he had pain with physical therapy. The patient had complaints of pain, stiffness, swelling, weakness, and popping and clicking to the right shoulder. The patient had complaints of pain, spasms, and stiffness to the low back. Upon examination, the straight leg test was positive at 80 degrees bilaterally. There was tenderness over the sacroiliac joint and the bilateral paralumbar area. The range of motion of the lumbar spine was flexion 30 inches from fingertip to floor, extension 10 degrees, lateral bending 15 degrees, and rotation 10 degrees. The muscle strength of the lumbar spine was 4/5 throughout. Examination of the right shoulder revealed tenderness of the acromioclavicular joint. The mid arc sign, drop test, Neer's sign, and Hawkins sign were all positive. The subluxation test was normal and examination of the shoulder revealed tenderness over the AC joint. The mid arc sign, the Neer's sign, the Hawkins sign, and the drop test were all positive. The subluxation test was normal. There was edema in the rib cage. Range of motion of the shoulder joints was flexion 130 degrees on the right and 90 degrees on the left, extension 30 degrees bilaterally, internal rotation 50 degrees on the right and 30 degrees on the left and external rotation was 60 degrees on the right and 30 degrees on the left. Muscle strength of the shoulders was 4/5 throughout, bilaterally. Examination of the right knee revealed tenderness of the medial lateral joint lines. There was laxity of the anterior cruciate ligament. The McMurray's test was normal and the neurovascular exam was normal. Examination of the left knee revealed tenderness of the medial and lateral joint lines. There was laxity of the anterior cruciate ligament. The McMurray's test was normal and the Apley's test was also normal. The neurovascular exam was normal. The ranges of motion of the knees were flexion at 90 degrees on the right and 100

degrees on the left and extension at 0 degrees. The muscle strength test was 4/5 throughout, bilaterally.

IMR ISSUES, DECISIONS AND RATIONALES

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

THE CONTINUATION OF PHYSICAL THERAPY OF THE LUMBAR SPINE: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

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

Decision rationale: The request for continued physical therapy of the lumbar spine 3 times 4 is medically necessary and appropriate. The Chronic Pain Medical Treatment Guidelines state that active therapy is based on the philosophy that therapeutic exercise and/or activity are beneficial for restoring flexibility, strength, endurance, function, and range of motion, and can alleviate discomfort. The recommended number of visits of physical therapy for myalgia and myositis are 9 to 10 visits over 8 weeks. The records provided for review failed to provide documentation of the number of visits of physical therapy the patient had completed to date and failed to include documentation of functional improvements gained from previous physical therapy to support additional physical therapy. In addition, the request for continued PT of the lumbar spine 3 times 4 exceeds the recommended number of visits of 9 to 10 over 8 weeks. Therefore, the request for continued physical therapy for the lumbar spine is not medically necessary and appropriate.

THE MOTORIZED WHEELCHAIR: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Power Mobility Devices Page(s): 99.

Decision rationale: The Chronic Pain Medical Treatment Guidelines state that powered mobility devices are not recommended if the function mobility deficit can be sufficiently resolved by prescription of a cane or a walker, or the patient has significant upper extremity function to propel a manual wheelchair, or if there is a care giver who is available, willing, and able to provide assistance with a manual wheelchair. The records submitted for review indicated the muscle strength of the lumbar spine and of the bilateral shoulders was 4/5 throughout. The documentation provided for review indicates that the patient has sufficient upper extremity function to propel a manual wheelchair. Therefore, the request for a motorized wheelchair is not medically necessary and appropriate.

THE TENS UNIT: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines TENS Page(s): 114-115.

Decision rationale: The Chronic Pain Medical Treatment Guidelines state that a TENS unit for chronic pain is not recommended as a primary treatment modality, The guidelines state that a one month home based TENS trial may be considered as a noninvasive conservative option if used as an adjunct to a program of evidence based functional restoration for the following conditions: a home based treatment trial of 1 month may be appropriate for neuropathic pain and CRPS II and for CRPS I, in neuropathic pain there is some evidence including diabetic neuropathy and postherpetic neuralgia. A TENS may be a supplement to medical treatment in the management of spasticity and spinal cord injury and while TENS does not appear to be effective in reducing spasticity in MS patients, it may be useful in treating MS patients with pain and muscle spasm. The records provided for review failed to include documentation of a one month home based TENS trial, and failed to include documentation of a diagnosis of CRPS I, CRPS II, diabetic neuropathy, phantom limb pain, spasticity in spinal cord injury, or multiple sclerosis to support the use of a TENS unit. Therefore, the request for a TENS Unit is not medically necessary and appropriate

THE CERVICAL PILLOW: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (OGD), Neck and Upper Back, Pillow

Decision rationale: The Official Disability Guidelines state recommended use of a neck support pillow while sleeping, in conjunction with daily exercise. The RCT concluded that subjects with chronic neck pain should be treated by health professionals trained to teach both exercises and the appropriate use of a neck support pillow during sleep; either strategy alone did not give the desired clinical benefit. The records submitted for review failed to include documentation that the patient was participating in a home exercise program. In addition, the records provided for review failed to indicate the patient would be taught both exercise and the appropriate use of neck support pillow during sleep. Therefore, the requested cervical pillow is not medically necessary and appropriate.