

Case Number:	CM13-0058355		
Date Assigned:	12/30/2013	Date of Injury:	03/02/2012
Decision Date:	05/05/2014	UR Denial Date:	11/06/2013
Priority:	Standard	Application Received:	11/26/2013

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, 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 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 46-year-old female with a date of injury of 03/02/2012. The listed diagnoses per [REDACTED] are sprain/strain cervical spine with left upper extremity radiculopathy, multilevel cervical disk bulge, cervical spine spondylosis, sprain/strain thoracic spine, sprain/strain lumbar spine with bilateral lower extremity radiculopathy, multilevel lumbar disk bulge with bilateral neural foraminal narrowing, lumbar spine spondylosis with degenerative disk disease, status post arthroscopic surgery of left shoulder, carpal tunnel syndrome, bilateral wrist, contusion/sprain/strain, bilateral knees, status post arthroscopic surgery of right knee, anxiety/depression, insomnia, exogenous obesity and hyperlipidemia. According to report dated 10/02/2013 by [REDACTED], the patient present with low, mid and neck pain. Provider states that medications, physiotherapy and chiropractic treatment are helping and IF unit has relieved her back symptoms and is taking less medications. Physical examination revealed palpable tenderness noted in the cervical, thoracic and lumbar paraspinal. Active range of motion in the cervical and lumbar was full with complaints of pain on all planes. Provider recommends "continue present medications as previously directed by primary care physician," referral to psychologist, physical therapy, chiropractic visits, home treatment exercise program, paraffin bath unit, and continue IF unit. Primary treating physician report by [REDACTED] on 09/04/2013 reports, patient complains of persistent pain in the left shoulder and low back. She is getting temporary relief from chiro and IF unit. The medications include Toradol 60mg, Tramadol 50mg, Motrin 800mg, Omeprazole 20mg, Gaviscon.

IMR ISSUES, DECISIONS AND RATIONALES

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

EIGHT PHYSICAL THERAPY VISITS BETWEEN 10/2/2013 AND 12/19/2013:

Overtured

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

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

Decision rationale: This patient present with low, mid and neck pain. The provider is requesting 8 additional physical therapy sessions. As medical records document, the patient in 2013 received 32 physical therapy sessions. Four of those sessions were post operative therapy following the 07/01/2013 left shoulder surgery. The MTUS post surgical guidelines pg 26, 27 recommends 24 visits for shoulder arthroplasty. In this case, the provider does not specify which injury the requested 8 sessions are to address. Given the patient continues with right shoulder pain and has not received the full post operative 24 visits allowed following the arthroplasty, the requested 8 sessions are medically necessary and recommendation is for approval.

FOUR CHIROPRACTIC TREATMENT BETWEEN 10/25/2013 AND 12/19/2013: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Manual Therapy & Manipulation.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines MANUAL THERAPY AND MANIPULAITON Page(s): 58-59.

Decision rationale: This patient present with low, mid and neck pain. The provider is requesting 4 additional chiropractic treatments. The California MTUS recommends an optional trial of 6 visits over 2 weeks with evidence of objective functional improvement total of up to 18 visits over 6 to 8 weeks. For recurrences/flare-ups, reevaluate treatment success and if return to work is achieved, then 1 to 2 visits every 4 to 6 months. Utilization review dated 11/06/2013 documents that the patient was authorized 4 sessions on 08/12/2013. Whether these sessions took place and the results of the treatments are unknown as treatment reports are not provided for review. In this case, given the patient has already been authorized for four visits, an additional 4 cannot be authorized without documentation of objective functional improvement. Recommendation is for denial.

ONE HOME TREATMENT-EXERCISES REGIMEN AT HOME BETWEEN 10/2/2013 AND 12/19/2013: Upheld

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

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

Decision rationale: This patient present with low, mid and neck pain. The request is for "one home treatment, exercise regimen at home." I do not see in any of the reports a request for such treatment. The closest request provided is by [REDACTED], whom on 09/04/2013 recommends home treatment to include exercise regimen at home. In any case, the MTUS guidelines page 98, 99 under physical medicine states, "Patients are instructed and expected to continue active therapies at home as an extension of the treatment process in order to maintain improvement levels." This patient is authorized for 4 sessions of physical therapy which will incorporate a home exercise education and training. Recommendation is for denial.

ONE REQUEST TO CONTINUE USE OF PARAFFIN BATH UNIT BETWEEN 10/2/2013 AND 12/19/2013: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Forearm, Wrist and Hand (Acute & Chronic)

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

Decision rationale: This patient present with low, mid and neck pain. The request is for paraffin bath unit for patient's pain and symptoms of the wrist. The MTUS and ACOEM Guidelines do not discuss paraffin unit specifically. However, ODG Guidelines under wrist and hand has the following regarding paraffin wax baths, "Recommended as an option for arthritic hands if used as an adjunct to a program of evidence-based conservative care (exercise). According to a Cochrane review, paraffin wax baths combined with exercise can be recommended for beneficial short-term effects for arthritic hands." In this case, the patient has a diagnosis of carpal tunnel syndrome, but there are no discussions of arthritis, pain in the hand or wrists or adjunct conservative care. The requested paraffin unit is not medically necessary, and recommendation is for denial.

ONE REQUEST TO CONTINUE PRESENT MEDICATIONS BETWEEN 10/2/2013 AND 12/19/2013: 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 Pain Outcomes and Endpoints Page(s): 8-9.

Decision rationale: This patient present with low, mid and neck pain. The provider is recommending the patient continue her medications that had been dispensed by her primary care physician. The provider does not list the medication, dosage or reason for the medication. Prior

progress report by patient's primary treating physician does provide a list of medication and the provider may be requesting that these medications be continued. The California MTUS page 8 states that the provider must monitor the patient's progress and make appropriate treatment recommendations. Absent documentation as to exactly what medications are being requested, recommendation is for denial.

ONE REQUEST FOR CONTINUED USE OF A IF UNIT BETWEEN 10/2/2013 AND 12/19/2013: Overturned

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Interferential Current Stimulation Page(s): 118-120.

Decision rationale: This patient present with low, mid and neck pain. The provider is requesting an interferential current stimulation unit. Medical records document the patient was authorized an inferential unit in November 2012. The California MTUS Guidelines page 118 to 120 states interferential current stimulation is not recommended as an isolated intervention. "There is no quality evidence of effectiveness except in conjunction with recommended treatments including return to work, exercise, and medications, and limited evidence of improvement on those recommended treatments alone. The randomized trials that have evaluated the effectiveness of this treatment have included the studies for back pain, jaw pain, soft tissue shoulder pain, cervical pain, and post-operative knee pain." In this case, the provider notes the IF unit reduces pain and medication intake. Additionally, the patient is status post arthroscopic surgery of right knee on 01/17/2013. MTUS recommends IF units when used in conjunction with exercise and medication and when used for post -operative knee pain. Recommendation is for approval.