

Case Number:	CM13-0061519		
Date Assigned:	12/30/2013	Date of Injury:	08/05/1998
Decision Date:	04/14/2014	UR Denial Date:	11/07/2013
Priority:	Standard	Application Received:	12/05/2013

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 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 49-year-old female who reported an injury on 08/05/1998. The mechanism of injury was not specifically stated. The patient is currently diagnosed with lumbar sprain and cervical sprain. The latest physician progress report was submitted by [REDACTED] on 09/10/2013. The patient reported persistent pain with activity limitation. Physical examination was not provided. Treatment recommendations included a second opinion consultation with a spine specialist, a right knee MR arthrogram, an orthopedic mattress, motorized scooter, shower chair, cervical pillow, physical therapy, neurostimulation, continuation of current medications, a formal neurocognitive evaluation with testing, a formal Functional Capacity Evaluation, and vascular Doppler studies of bilateral lower extremities.

IMR ISSUES, DECISIONS AND RATIONALES

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

ACUPUNCTURE: Upheld

Claims Administrator guideline: Decision based on MTUS Acupuncture Treatment Guidelines.

MAXIMUS guideline: Decision based on MTUS Acupuncture Treatment Guidelines.

Decision rationale: The California MTUS Guidelines state acupuncture is used as an option when pain medication is reduced or not tolerated, and may be used as an adjunct to physical

rehabilitation and/or surgical intervention. The time to produce functional improvement includes 3 to 6 treatments with a frequency of 1 to 3 times per week. As per the documentation submitted, the patient has previously participated in a course of acupuncture therapy. However, there is no documentation of objective functional improvement following the initial course of treatment. The specific frequency and duration of treatment was not stated in the current request. Therefore, the request for Acupuncture is not medically necessary and appropriate.

AQUA THERAPY: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 22.

Decision rationale: The California MTUS Guidelines state aquatic therapy is recommended as an optional form of exercise therapy, where available as an alternative to land based physical therapy. There was no documentation of a physical examination on the requesting date of 09/10/2013. Therefore, it is unknown whether the patient requires reduced weight bearing as opposed to land based physical therapy. The specific frequency and duration of treatment was not stated in the current request. Therefore, the request cannot be determined as medically appropriate. As such, the request for Aqua therapy is not medically necessary and appropriate.

PHYSICAL THERAPY (WITH TRACTION & MODALITIES) TO CERVICAL AND LUMBAR: Upheld

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

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

Decision rationale: The California MTUS Guidelines state active therapy is based on the philosophy that therapeutic exercise and/or activity are beneficial for restoring flexibility, strength, endurance, function, range of motion, and can alleviate discomfort. Guidelines allow for a fading of treatment frequency plus active self-directed home physical medicine. As per the documentation submitted, the patient has previously participated in a course of physical therapy. However, there is no documentation of objective functional improvement. The frequency and duration of treatment was also not stated in the current request. Based on the clinical information received, the request for Physical therapy (with traction & modalities) to cervical and lumbar is not medically necessary and appropriate.

CT SCAN (COMPUTED TOMOGRAPHY) FOR CERVICAL AND LUMBAR SPINE:
Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): TABLE 8-8, 182 AND 303.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints, Chapter 12 Low Back Complaints Page(s): 177-179 AND 303-305.

Decision rationale: The California MTUS/ACOEM Practice Guidelines state if physiologic evidence indicates tissue insult or nerve impairment, the practitioner can discuss with a consultant the selection of an imaging test to define a potential cause, including MRI for neural or other soft tissue abnormality and computed tomography for bony structures. There was no documentation of a physical examination on the requesting date of 09/10/2013. There were no plain films obtained prior to the request for an imaging study. There is no documentation of an exhaustion of conservative treatment. There is also no evidence of a progression or worsening of symptoms or physical examination findings. The medical necessity has not been established. Therefore, the request for CT scan cervical and lumbar is not medically necessary and appropriate.

MRI OF CERVICAL AND LUMBAR SPINE: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): TABLE 8-8, 182 AND 303.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints, Chapter 12 Low Back Complaints Page(s): 177-179 AND 303-305.

Decision rationale: The California MTUS/ACOEM Practice Guidelines state if physiologic evidence indicates tissue insult or nerve impairment, the practitioner can discuss with a consultant the selection of an imaging test to define a potential cause, including MRI for neural or other soft tissue abnormality and computed tomography for bony structures. There was no documentation of a physical examination on the requesting date of 09/10/2013. There were no plain films obtained prior to the request for an imaging study. There is no documentation of an exhaustion of conservative treatment. There is also no evidence of a progression or worsening of symptoms or physical examination findings. The medical necessity has not been established. Therefore, the request for MRI of cervical and lumbar is not medically necessary and appropriate.

MR (MAGNETIC RESONANCE) ARTHROGRAM RIGHT KNEE: Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 13 Knee Complaints Page(s): 341-343.

Decision rationale: The California MTUS/ACOEM Practice Guidelines state special studies are not needed to evaluation most knee complaints until after a period of conservative care and

observation. As per the documentation submitted, the patient maintains a diagnosis of lumbar sprain and cervical sprain. There is no indication of a significant musculoskeletal or neurological deficit with regard to the right knee. There was no physical examination provided on the requesting date of 09/10/2013. There is also no documentation of an exhaustion of conservative treatment. Based on the clinical information received, the request for MR arthrogram right knee is not medically necessary and appropriate.

BOTOX INJECTION TO LUMBAR SPINE AND FOR HEADACHES: Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 301. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back Chapter, Botulinum toxin (Botox®)

Decision rationale: The California MTUS/ACOEM Practice Guidelines state invasive techniques are of questionable merit. The Official Disability Guidelines state Botox injections are currently under study for chronic low back pain. As per the documentation submitted, there is no evidence of a physical examination on the requesting date of 09/10/2013. There is also no evidence of an exhaustion of conservative treatment prior to the request for a Botox injection. Based on the clinical information received, the request for Botox injection to lumbar spine and for headaches is not medically necessary and appropriate.

SACROILIAC JOINT INJECTIONS: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG-TWC Hip and Pelvis Chapter

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Hip & Pelvis Chapter, Sacroiliac Joint Blocks

Decision rationale: The Official Disability Guidelines state history and physical should suggest a diagnosis with documentation of at least 3 positive examination findings. As per the documentation submitted, there was no evidence of a comprehensive physical examination provided on the requesting date of 09/10/2013. There is no documentation of 3 positive examination findings suggestive of sacroiliac etiology. There is also no evidence of a failure to respond to 4 to 6 weeks of aggressive conservative therapy. Based on the clinical information received, the request for SI joint injections is not medically necessary and appropriate.

FACET INJECTIONS: Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 301.

Decision rationale: California MTUS/ACOEM Practice Guidelines state invasive techniques such as facet joint injections are of questionable merit. There was no documentation of a physical examination on the requesting date. There were no imaging studies provided for review. The specific location at which the facet injections will be administered was not stated in the request. Based on the clinical information received, the request of Facet Injections is not medically necessary and appropriate.

H-WAVE PADS AND ELECTRICAL PLUG: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines H-Wave Stimulation (HWT).

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

Decision rationale: California MTUS Guidelines state H-wave stimulation is not recommended as an isolated intervention, but a 1 month home-based trial may be considered as a non-invasive conservative option for diabetic neuropathic pain or chronic soft tissue inflammation. As per the documentation submitted, the patient currently utilizes an H-wave stimulation unit. Despite ongoing treatment, the patient continues to report persistent pain. There is no documentation of objective functional improvement. Therefore, the current request cannot be determined as medically necessary. As such, the request for H-Wave pads and electrical plug is not medically necessary and appropriate.

PERCUTANEOUS NEUROSTIMULATOR: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Percutaneous Electrical Nerve Stimulation (PENS).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 97.

Decision rationale: California MTUS Guidelines state percutaneous electrical neurostimulation is not recommended as a primary treatment modality, but a trial may be considered if used as an adjunct to a program of evidence-based functional restoration. As per the documentation submitted, there is no evidence of this patient's active participation in a functional restoration program. There is also no evidence of a failure to respond to conservative treatment including therapeutic exercise and TENS therapy. Therefore, the current request of Percutaneous Neurostimulator cannot be determined as medically necessary and appropriate.

HEMOCARE, EIGHT (8) HOURS/DAY FOR SEVEN (7) DAYS/WEEK FOR ONE (1) MONTH: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 51.

Decision rationale: California MTUS Guidelines state home health services are recommended only for otherwise recommended medical treatment for patients who are homebound on a part-time or intermittent basis, generally up to no more than 35 hours per week. As per the documentation submitted, there is no indication that this patient is homebound. There is also no evidence of a physical examination, documenting a significant musculoskeletal or neurological deficit. The current request for home care 8 hours per day, 7 days per week, exceeds guideline recommendations. Based on the clinical information received, the request of decision for Homecare, eight (8) hours/day for seven (7) days/week for one (1) month is not medically necessary and appropriate is not medically necessary and appropriate.

MEDICAL TRANSPORTATION TO ALL MEDICAL APPOINTMENTS: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Knee & Leg Chapter, Transportation to and from appointments

Decision rationale: Official Disability Guidelines state transportation to and from appointments is recommended for medically necessary transportation to appointments in the same community for patients with disabilities preventing them from self-transport. There was no physical examination provided on the requesting date of 09/10/2013. The medical necessity for the requested service has not been established. There is no indication that this patient suffers from a disability that prevents them from self-transport. There is also no indication as to why this patient cannot utilize public transportation. Based on the clinical information received, therefore the request for medical transportation to all medical appointments is not medically necessary and appropriate.

SECOND OPINION CONSULT WITH [REDACTED]: Upheld

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

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

Decision rationale: California MTUS/ACOEM Practice Guidelines state referral may be appropriate if the practitioner is uncomfortable with the line of inquiry, with treating a particular cause of delayed recovery, or has difficulty obtaining information or agreement to a treatment

plan. As per the documentation submitted, there is no evidence of an exhaustion of conservative treatment prior to the request for a referral. The medical necessity has not been established. There was no physical examination provided on the requesting date. Based on the clinical information received, the request of for second opinion consultation with [REDACTED] is not medically necessary and appropriate.

ANATOMICAL RATING: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation National Library of Medicine, Dopf CA, Mandel SS, Geiger DF, Mayer PJ, Spine.1995 Jan 15;20(2):252-3

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

Decision rationale: California MTUS/ACOEM Practice Guidelines state referral may be appropriate if the practitioner is uncomfortable with the line of inquiry, with treating a particular cause of delayed recovery, or has difficulty obtaining information or agreement to a treatment plan. There was no physical examination provided on the requesting date. There is no evidence of an exhaustion of conservative treatment. The medical necessity has not been established. Based on the clinical information received, the request is not medically necessary and appropriate.