

Case Number:	CM14-0002926		
Date Assigned:	01/24/2014	Date of Injury:	05/03/2013
Decision Date:	11/24/2014	UR Denial Date:	12/10/2013
Priority:	Standard	Application Received:	01/08/2014

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 Occupational Medicine 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 75 year-old female with date of injury 05/03/2013. The medical document associated with the request for authorization, a primary treating physician's progress report, dated 12/17/2013, lists subjective complaints as pain in the lumbar spine, right elbow, bilateral knees, bilateral shoulders, face, bilateral hands and wrists, bilateral hips, and thoracic spine. Objective findings: Thoracic spine: +3 spasm and tenderness to the bilateral thoracic paraspinal muscles from T1 to T9. Lumbar Spine: +3 spasm and tenderness to the bilateral lumbar paraspinals muscles from L1 to S1. Kemp's test was positive bilaterally. Straight leg test was positive on the right. Yeoman's was positive bilaterally. Braggard's was negative. Shoulders: +3 spasm and tenderness. Speeds test was positive bilaterally. Supraspinatus test was positive bilaterally. Elbows: Neurological exam of the bilateral upper extremities was within normal limits bilaterally for deep tendon reflexes, dermatomes and myotomes. +3 spasm and tenderness to the right lateral epicondyle and right olecranon. Wrists and hands: +3 spasm and tenderness to the bilateral tensor fasciae muscles. Fabere's test was positive bilaterally. Diagnoses are lumbar disc displacement with myelopathy; thoracic disc displacement without myelopathy; tendinitis/ bursitis of the bilateral hands/ wrists; carpal tunnel syndrome; bursitis and tendinitis of bilateral shoulders; tear of medial meniscus of the bilateral knees; tendinitis; bursitis of bilateral hips; bursitis of bilateral knees; tendinitis/ bursitis of bilateral hips; lateral epicondylitis of the right elbow; olecranon bursitis of the right elbow. The patient has completed 44 sessions of physical therapy to date.

IMR ISSUES, DECISIONS AND RATIONALES

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

Physical medicine visits for the lumbar spine and right elbow to include electrical muscle stimulation, infrared, chiropractic manipulative therapy, myofascial release and therapeutic activities, 6 visits: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Guidelines Page(s): 99. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back and Elbow Chapters, Physical therapy

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 58-60.

Decision rationale: The MTUS 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, range of motion, and can alleviate discomfort. Continued physical therapy is predicated upon demonstration of a functional improvement. There is no documentation of objective functional improvement. In addition, California Labor Code Section 4604.5(c) (1) states that an employee shall be entitled to no more than 24 chiropractic, 24 occupational therapy, and 24 physical therapy visits per industrial injury. The medical record indicates that the patient has previously undergone at least 44 sessions of physical therapy. During the previous physical therapy sessions, the patient should have been taught exercises which are to be continued at home as directed by MTUS. Physical medicine visits for the lumbar spine and right elbow to include electrical muscle stimulation, infrared, chiropractic manipulative therapy, myofascial release and therapeutic activities, 6 visits is not medically necessary.

One month rental of a multi-interferential stimulator: Upheld

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

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

Decision rationale: According to the MTUS Chronic Pain Medical Treatment Guidelines, an interferential current stimulation (ICS) 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. A TENS unit without interferential current stimulation is the recommended treatment by the MTUS. One month rental of a multi-interferential stimulator is not medically necessary.

Lumbar support orthosis: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 298-301. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back, Lumbar supports

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

Decision rationale: According to the MTUS ACOEM Practice Guidelines, lumbar supports have not been shown to have any lasting benefit beyond the acute phase of symptom relief. Therefore, lumbar support orthosis is not medically necessary.

Functional capacity evaluation: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ACOEM, Chapter 7 Independent Medical Examinations and Consultations, page 132-139

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Fitness for Duty, Functional capacity evaluation (FCE)

Decision rationale: The Official Disability Guidelines state that a functional capacity evaluation is appropriate if, case management is hampered by complex issues and the timing is appropriate; such as if the patient is close to being at maximum medical improvement or additional clarification concerning the patient's functional capacity is needed. Functional capacity evaluations are not needed if the sole purpose is to determine a worker's effort or compliance, or the worker has returned to work. There is no documentation in the medical record to support a functional capacity evaluation based on the above criteria. Functional capacity evaluation is not medically necessary.