MAXIMUS Federal Services

Case Number:	CM14-0110185		
Date Assigned:	08/01/2014	Date of Injury:	03/29/2014
Decision Date:	09/09/2014	UR Denial Date:	06/30/2014
Priority:	Standard	Application Received:	07/15/2014

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 Physical Medicine and Rehabilitation 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 underlying date of injury in this case is 03/29/2014. The reference diagnoses include ankle and foot sprain, lumbar sprain, neck sprain, and shoulder/arm sprain. As of 04/11/2014, the patient was seen in initial primary treating physician evaluation regarding his multifocal cumulative trauma injury. The treating physician reviewed past treatment in detail regarding cervical and lumbar sprain, left foot pain, and right shoulder sprain and recommended extensive treatment including getting physical therapy, urinalysis, a lumbar support, and obtaining multiple x-rays and also prescribing medications including topical cream, salicylate, Orphenadrine, Cyclobenzaprine, and Naproxen as well as a functional capacity evaluation to determine the patient's ability to return to his usual occupation. On 05/14/2014, the patient reported ongoing pain in the cervical and lumbar spine, right shoulder, and right foot with tenderness to palpation in these areas and associated spasm and decreased range of motion. No specific focal neurological deficits were noted. An initial physician review on 06/30/2014 recommended that multiple requests be noncertified. These included requests for chromatography, referring for urine drug testing, with the rationale that there was no indication that the patient was being treated with opioid medications.

IMR ISSUES, DECISIONS AND RATIONALES

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

Physical Therapy 2-3 x 4 weeks with multiple modalities to shoulder, neck, lumbar and foot: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Page(s): 114. Decision based on Non-MTUS Citation http://www.odg-twc.com/preface.htm#PhysicalTherapyGuidelines.

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

Decision rationale: The California Medical Treatment Utilization Schedule Chronic Pain Medical Treatment Guidelines, section on Physical Medicine, recommend allowing for fading of treatment frequency and transition to an independent home rehabilitation program. These guidelines anticipate that this patient would have transitioned to an independent rehabilitation program by the time of this review. The records do not provide an alternative rationale instead for additional supervised therapy. This request is not medically necessary.

MRI Lumbar Spine: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303-304. Decision based on Non-MTUS Citation Official Disability Guidelines, Low Back Chapter.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 309.

Decision rationale: The ACOEM Guidelines, chapter 12 low back, page 309, recommend MRI imaging of the lumbar spine when red flag factors exist including deficits on neurological examination. The medical records do not discuss a rationale for a lumbar MRI in this case and particularly do not discuss such a request in the context of prior lumbar MRI imaging. Overall the medical records and guidelines do not support an indication for a lumbar MRI. This request is not medically necessary.

MRI Right Shoulder: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Shoulder Chapter.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 209.

Decision rationale: The ACOEM Guidelines, chapter 9 Shoulder, page 209, state that relying on imaging to evaluate the source of shoulder symptoms carries a significant risk of diagnostic confusion. Implicit in this guideline is that a request for an MRI should be in the context of a specific differential diagnosis. The medical records do not contain such a rationale at this time to explain the need for an MRI of the shoulder. This request is not medically necessary.

Transcutaneous Nerve Stimulator (TENS) unit: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 114-116.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Transcutaneous Electrical Nerve Stimulation, Pages 116-117 Page(s): 116-117.

Decision rationale: The California Medical Treatment Utilization Schedule Chronic Pain Medical Treatment Guidelines, section on transcutaneous electrical nerve stimulation, state that a one-month home-based TENS trial may be used as part of an overall functional restoration program for neuropathic pain. The medical records do not document the results of her prior TENS rental/trial. Additional records do not clearly document ongoing neuropathic pain. This request is not supported by the treatment guidelines. This request is not medically necessary.

Retrospective request for Chromatography (no date provided): Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 43, 78.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Drug Testing, Page 43 Page(s): 43.

Decision rationale: The California Medical Treatment Utilization Schedule Chronic Pain Medical Treatment Guidelines, section on drug testing, state that this is an option in order to assess for the use or presence of illegal drugs. A prior physician review recommended not medically necessary for this request with the rationale that there was no indication that this patient was being prescribed opioid medication. However, particularly in the current context where a new physician has assumed treatment of a patient with a chronic pain syndrome, assessing the patient's clinical status, including a baseline to rule out potential sources opioid medications or other drugs of abuse, would be supported by the treatment guidelines. Therefore, this request is medically necessary.