

Case Number:	CM14-0113399		
Date Assigned:	08/01/2014	Date of Injury:	01/28/2013
Decision Date:	09/10/2014	UR Denial Date:	06/10/2014
Priority:	Standard	Application Received:	07/18/2014

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, 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 51 year old with an injury date on 1/28/13. Patient complains of constant, throbbing cervical pain radiating to upper/mid back with headaches, constant localized wrist/finger pain with numbness/tingling/weakness, occasional lumbar pain radiating to both lower extremities with giving way and weakness, and constant bilateral knee pain that is localized, with cracking sensations and weakness, and occasional pressure pain in the feet radiating to the toes per 5/21/14 report. Patient had a year of chiropractic treatments in 1999 with no benefit, 2 acupuncture treatments in 2009 with temporarily relief, and otherwise has been self-treating with Tylenol/medicated patches to lower back for over 10 years with no other medical care received per 5/21/14 report. Based on the 5/21/14 progress report provided by [REDACTED] the diagnoses are: 1. cervical s/s and cervicogenic headaches 2. Lumbar s/s with scoliosis 3. Bilateral knee s/s 4. Bilateral wrist s/s 5. Finger s/s 6. Bilateral feet s/s with Achilles tendon calcaneal heel spurs bilaterally Exam on 5/21/14 showed muscle guarding and muscle spasm on the right. C-spine range of motion: moderately diminished. Wrist range of motion: normal. L-spine range of motion: flexion decreased by 50%. Knee range of motion: normal but with patellofemoral pain and crepitation on range of motion. Ankle range of motion: normal but tenderness to palpation over forefeet bilaterally. [REDACTED] is requesting Chiropractic Treatment 3x per week for 4 weeks to the Cervical and Lumbar Spine, initial functional capacity evaluation, Cyclo/Keto/Lido (strength and quantity not provided), and interferential (IF) unit. The utilization review determination being challenged is dated 6/6/14. [REDACTED] is the requesting provider, and he provided treatment reports from 5/22/14 to 6/23/14.

IMR ISSUES, DECISIONS AND RATIONALES

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

Chiropractic treatment, 3 x per week for 4 weeks, to the cervical and lumbar spine: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 58.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Chapter on Manual Therapy and Treatments, Pages 58-59 Page(s): 58-59.

Decision rationale: This patient presents with neck pain, back pain radiating to legs, bilateral wrist/finger pain, and bilateral knee/foot pain. The treater has asked for chiropractic treatment 3x per week for 4 weeks to the cervical and lumbar spine on 5/21/14. Review of the report shows patient had Chiropractic Treatments more than 10 years ago with no relief. MTUS guidelines allow up to 18 sessions of treatments following initial trial of 3-6 if functional improvements can be documented. In this case, a trial of 3-6 sessions would be deemed reasonable, but the requested 12 Chiropractic Sessions exceeds MTUS guidelines for this type of condition. Recommendation is therefore, not medically necessary.

Initial Functional Capacity Evaluation (FCE): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 125. Decision based on Non-MTUS Citation ACOEM Guidelines Chapter 7, page 138.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Chapter 7, pgs. 137-138.

Decision rationale: This patient presents with neck pain, back pain radiating to legs, bilateral wrist/hand/finger pain, and bilateral knee/foot pain. The treater has asked for initial functional capacity evaluation on 5/21/14. Patient has been working for 20 years with gradually worsening pain, and has recently stopped working in April 2014 and has not worked since per 5/21/14 report. Regarding functional capacity evaluations, MTUS is silent, but ACOEM does not recommend them due to their oversimplified nature and inefficacy in predicting future workplace performance. Functional Capacity Evaluation (FCE's) are indicated for special circumstances and only if it is crucial. It can be ordered if asked by administrator or the employer as well. In this case, the treater does not indicate any special circumstances that would require a functional capacity evaluation. Routine FCE's is not supported by the guidelines. Recommendation is therefore, not medically necessary.

Cyclo/Keto/Lido (strength and quantity not provided): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 111-112.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Medicine Page(s): 111-113.

Decision rationale: This patient presents with neck pain, back pain radiating to legs, bilateral wrist/hand/finger pain, and bilateral knee/foot pain. The treater has asked for Cyclo/Keto/Lido (strength and quantity not provided) on 5/21/14. MTUS states any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. MTUS does not recommend any muscle relaxant for topical use. As topical Cyclobenzaprine is not indicated, the entire Cyclo/Keto/Lido compound would also not be indicated. Recommendation is therefore, not medically necessary.

Interferential (IF) unit: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines (TENS) Transcutaneous electrotherapy, Interferential Current Stimulation (ICS) Transcutaneous electrotherapy Interferential Current Stimulation (ICS).

Decision rationale: This patient presents with neck pain, back pain radiating to legs, bilateral wrist/hand/finger pain, and bilateral knee/foot pain. The treater has asked for an interferential (IF) unit on 5/21/14. Per MTUS Guidelines, interferential units are recommended if medications do not work history of substance abuse or for post-operative pain control. In this case, the patient's records do not indicate that medications are not effective, and there is no history of substance abuse or any operations other than a 2009 left abdominal surgery for diverticulitis. The treater does not explain the necessity of requested interferential unit. When IF unit indicated, then a month trial use is first recommended. The current request is for a purchase. Recommendation is therefore, not medically necessary.

