MAXIMUS Federal Services

Case Number:	CM14-0114150		
Date Assigned:	08/04/2014	Date of Injury:	02/19/2014
Decision Date:	10/08/2014	UR Denial Date:	06/30/2014
Priority:	Standard	Application Received:	07/22/2014

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 Nevada. 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 records, presented for review, indicate that this 48-year-old individual was reportedly injured on February 19, 2014. The mechanism of injury was noted as repetitive overuse. The most recent progress note, dated April 16, 2014, indicated that there were ongoing complaints of multiple sites of pain. The physical examination demonstrated a 5'2", 127 pound individual who was hypertensive (169/96). The cervical spine was tender to palpation, and a slight decrease in range of motion was noted. A marked decrease in shoulder range of motion was reported, which was painful throughout the ark of motion. A decrease in lumbar spine range of motion was also noted. Diagnostic imaging studies objectified the lumbar spine MRI was completed on June 4, 2014 and noted multiple level degenerative changes. An MRI of the left knee was completed on June 3, 2014, which identified a tear of the medial meniscus. A right shoulder MRI was completed on May 30, 2014 and identified acromioclavicular joint osteoarthritis as well as a tendinitis of the rotator cuff. Previous treatment included a functional capacity evaluation having been completed on May 5, 2014. Computerized range of motion testing was also completed. A request had been made for MRI, lumbar brace and physical therapy and was not certified in the pre-authorization process on June 30, 2014.

IMR ISSUES, DECISIONS AND RATIONALES

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

Magnetic Resonance Imaging (MRI) lumbar spine: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303-304, table 12-8. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back Chapter

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints.

Decision rationale: ACOEM practice guidelines support a MRI of the lumbar spine for patients with subacute or chronic radiculopathy lasting at least 4 to 6 weeks if symptoms are not trending towards improvement, and if both the patient and surgeon are considering prompt surgical treatment. However, an MRI was completed recently and there is no clinical data presented to suggest that a repeat study is necessary. Therefore, the medical necessity has not been established.

LSO (Lumbar-Sacral Orthosis) brace: Upheld

Claims Administrator 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

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

Decision rationale: MTUS/ACOEM practice guidelines do not support the use of a LSO or other lumbar support devices for the treatment or prevention of low back pain except in cases of specific treatment of spondylolisthesis, documented instability, or postoperative treatment. The claimant is currently not in an acute postoperative setting and there is no documentation of instability or spondylolisthesis with flexion or extension plain radiographs of the lumbar spine. As such, this request is not considered medically necessary.

Physiotherapy two (2) times a week, up to twenty-four (24) visits: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 98-99. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back Chapter, Neck and Upper Back Chapter, Shoulder Chapter, and Knee Chapter; http://www.odg-twc.com/preface.htm#PhysicalTherapyGuidelines

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints.

Decision rationale: When considering the date of injury, the findings noted on physical examination and by the parameters outlined in the ACOEM guidelines, there is no recommendation for 24 sessions of physical therapy based on the clinical information noted. At most, a home exercise protocol is to be supported. Therefore, based on the clinical information presented for review, this is not medically necessary.

Chiropractic treatment two (2) times five (5) (10): Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 173. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Neck/Upper Back Chapter

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

Decision rationale: CA MTUS guidelines support the use of manual therapy and manipulation (chiropractic care) for low back pain as an option. A trial of 6 visits over 2 weeks with the evidence of objective functional improvement and a total of up to #18 visits over 16 weeks is supported. However, there are other conservative measures that are being employed and there has not been any analysis as to the efficacy of those interventions. At best, this intervention would be premature and is not medically necessary at this time.

Diathermy, massage, EMS, and ultrasound two (2) times five (5) (10): Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 298-299.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 162, 300.

Decision rationale: When considering the date of injury, the most recent physical examination offered and the lack of any competent, objective and independently confirmable medical evidence to suggest any efficacy, utility or benefit from such intervention, there is no clear clinical data presented to support this intervention. As such, when noting the data presented, this request is not medically necessary.

Computerized ROM (Range of Motion) of cervical spine, lumbar spine, and upper/lower extremities: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back Chapter

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints.

Decision rationale: When noting the date of injury, the injury sustained, the treatment rendered, and the findings identified on physical examination, there is no clear clinical indication presented for the need for computerized range of motion testing. Range of motion assessment can be easily completed during a routine office visit using a standard goniometer. As such, there is no medical necessity for such testing.