

Case Number:	CM14-0024658		
Date Assigned:	06/16/2014	Date of Injury:	11/25/2013
Decision Date:	07/16/2014	UR Denial Date:	02/12/2014
Priority:	Standard	Application Received:	02/26/2014

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 & 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 patient is a 36-year-old female who was injured on 11/25/2013 due to repetitive work. Prior treatment history not been submitted in the medical records. Diagnostic studies reviewed include MI of the cervical spine dated 05/05/2014 revealed C6-C7 normal disc height. There are mild endplate degenerative changes. There is a 1 mm midline disc bulge. There is mild effacement of the anterior thecal sac with no central canal narrowing. There is no cord compression identified. MRI of the thoracic spine dated 05/06/2014 revealed an unremarkable MRI. There was normal alignment with no compression fracture. There is no disc protrusion or central canal stenosis. MRI of the lumbar spine w/o contrast dated 05/29/2014 revealed there is no scoliotic curvature. At L5-S1 there is a 1 mm circumferential disc bulge with no disc protrusion. There is no compression fracture or marrow edema. Progress note dated 02/12/2014 documented the patient complained of intermittent severe pain described as sharp in the cervical spine. The pain is aggravated by prolonged standing and laying face up associated with headache and dizziness, shaking and nausea. Also the patient complained of intermittent to moderate severe pain at the thoracic spine lesion aggravated by bending forward. The patient reported tingling and pain radiated to her lower back. She also had intermittent moderate to severe pain in her lumbar spine described as throbbing. She had complaints of moderate pain described as sharp with increased prolonged standing in the knees, left worse than right. Objective findings on examination of the cervical spine revealed there was +3 spasm and tenderness to the bilateral paraspinal muscles from C2 to C7, bilateral suboccipital muscles and bilateral upper shoulder muscles. Cervical range of motion was captured digitally by Acumar. Axial compression test was positive bilaterally for neurological compromise. Distraction test was positive bilaterally. Shoulder depression test was positive bilaterally. There was +34 spasm and tenderness to the bilateral thoracic paraspinal muscles from T1 to T8. There was 3+ spasm and tenderness to the bilateral

lumbar paraspinal muscles from L2 to S1 and multifidus. There was +2 spasm and tenderness to the bilateral piriformis muscles. Kemp's test was positive bilaterally. Straight leg raise was positive on the left. Yeoman's was positive bilaterally. Braggard's was negative. The left Achilles reflex was decreased. On knee examination there was +3 spasm and tenderness to the bilateral anterior and medial joint lines. McMurray's test was positive bilaterally. Grinding test was positive bilaterally. Clarke's test was positive bilaterally. Diagnoses: cervical disc herniation with myelopathy; lumbar spondylosis with myelopathy; thoracic spondylosis with myelopathy; and chondromalacia patella of the bilateral knees. Treatment Plan: The patient was prescribed topical compound (Lidocaine 6%, gabapentin 10%, tramadol 10%). For muscular pain topical compound (Flurbiprofen 15%, cyclobenzaprine 2\$, Baclofen 2%, lidocaine 5%). The patient needs a neurological consultation as well as internal medicine consultation. Utilization report dated 02/12/2014 states the request for physical medicine plus chiropractic manipulative therapy to the cervical, thoracic and lumbar spine, multi-interferential stimulator rental and lumbar orthosis were only partially certified with physical therapy being modified to 10 visit and not 12. There is no supportive documentation to exceed the recommendation for 12 visits of physical therapy. For the request on the interferential stimulator, there is no documentation of any medication or drug abuse and no documentation that the injured worker cannot exercise. The request for lumbar lordosis was denied because back supports are not supported for chronic back pain. The injury is not acute and there is no documentation of fracture or unstable spondylolisthesis. Core strengthening is recommended not immobilization.

IMR ISSUES, DECISIONS AND RATIONALES

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

PHYSICAL MEDICINE/CHIROPRACTIC MANIPULATIVE THERAPY TO CERVICAL, THORACIC, AND LUMBAR SPINE, QTY 12: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine & Manual Therapy and Manipulation Page(s): 58-59, 98-99.

Decision rationale: As per CA MTUS Guidelines, physical medicine 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. The guidelines recommend active treatment over passive with physical therapy (PT) for home exercise instruction. Chronic pain guidelines recommends up to 8-10 visits. There is no supporting documentation to exceed the recommended guidelines. It is recommended that the request for treatment be re-submitted requesting 10 sessions. Regarding chiropractic treatment, the guidelines recommend trial of 6 visits over 2 weeks, with evidence of objective functional improvement. The request for 12 visits exceeds the guidelines recommendation and therefore is not medically necessary.

MULTI-INTERFERENTIAL STIMULATOR RENTAL 30 DAY RENTAL: 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 Interferential Current Stimulation (ICS) Page(s): 118-120. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG).

Decision rationale: As per CA MTUS, 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. For the request on the interferential stimulator, there is no documentation of any medication or drug abuse and no documentation that the injured worker cannot exercise. This request is not medically necessary.

LUMBOSACRAL ORTHOSIS, QTY 1: Upheld

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

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

Decision rationale: As per ACOEM guidelines, there is no evidence for the effectiveness of lumbar supports in preventing back pain in industry. As per ODG, lumbar supports are "Not recommended for prevention. There is strong and consistent evidence that lumbar supports were not effective in preventing neck and back pain." The request for lumbar orthosis is denied because back supports are not supported for chronic back pain. The injury is not acute and there is no documentation of fracture or unstable spondylolisthesis. Core strengthening is recommended not immobilization. Therefore, the request is not medically necessary.