

Case Number:	CM14-0039047		
Date Assigned:	06/27/2014	Date of Injury:	05/07/2013
Decision Date:	08/19/2014	UR Denial Date:	03/19/2014
Priority:	Standard	Application Received:	04/03/2014

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 19-year-old female was reportedly injured on 5/7/2013. The mechanism of injury was cleaning a window with her right arm, while working as a cashier, at a pizza restaurant. A progress note, dated 2/27/2014, indicated that there were ongoing complaints of neck, right shoulder, mid back and right upper extremity pains. Physical examination demonstrated +3 spasm and tenderness of the cervical, thoracic and lumbar paraspinal muscles, decreased range of motion of the cervical and lumbar spine due to pain, positive axial compression test bilaterally, decreased right biceps and brachioradialis reflexes, decreased sensation in the right C5, C6, C8 dermatomes, weakness in the right C5, C6, C8 myotones, Kemp's test positive, straight leg test negative, Achilles reflexes symmetrical and decreased, normal lower extremity sensation and muscle testing, +3 to +4 spasm and tenderness to the right shoulder, elbow, wrist and hand with decreased range of motion due to pain, positive Codman's/Speeds/Supraspinatus tests on the right, positive Tinel's and Bracelet tests on the right shoulder. Plain radiographs, dated 5/11/2013, were normal. Previous treatment included muscle relaxers and pain medications. A request was made for twelve sessions of physical therapy, interferential stimulator one month rental and lumbosacral orthoses and was not certified in the utilization review on 3/19/2014.

IMR ISSUES, DECISIONS AND RATIONALES

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

Physical therapy 12 sessions: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Page(s): 99. Decision based on Non-MTUS Citation Official Disability Guidelines-Neck and upper back-Low back-Lumbar & Thoracic (Acute and Chronic).

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

Decision rationale: Chronic Pain Medical Treatment Guidelines support the use of physical therapy for the management of chronic pain specifically myalgia and radiculitis. It recommends a maximum of 8-10 visits over 4 weeks. The current request for twelve physical therapy visits exceeds the amount supported by the chronic pain treatment guidelines. As such, this request is not considered medically necessary.

Request for multiinterferential stimulator, one month rental: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Transcutaneous electrotherapy Page(s): 116, 120, and 121.

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

Decision rationale: Chronic Pain Medical Treatment Guidelines do not support interferential therapy as an isolated intervention. Guidelines will support a one-month trial in conjunction with physical therapy, exercise program and a return to work plan, if chronic pain is ineffectively controlled with pain medications or side effects to those medications. Review of the available medical records, failed to document any of the criteria required for an interferential Unit one-month trial. As such, this request is not medically necessary.

Lumbar-sacral 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-Lumbar supports.

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

Decision rationale: American College of Occupational and Environmental Medicine treatment guidelines do not support the use of a lumbosacral orthosis (LSO) or other lumbar-sacral support device 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 and on plain radiographs of the lumbar spine. As such, this request is not considered medically necessary.