

Case Number:	CM14-0049824		
Date Assigned:	08/01/2014	Date of Injury:	12/24/2006
Decision Date:	08/29/2014	UR Denial Date:	04/14/2014
Priority:	Standard	Application Received:	04/17/2014

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 injured worker is a 55-year-old female who reported an injury on 12/24/2006. The mechanism of injury was not provided. On 04/01/2014, the injured worker presented with low back and neck pain. She also reported diminished sensation in the right lower extremity. Upon examination of the cervical spine, there was limited range of motion and tenderness to palpation about both occiputs, bilateral upper back, bilateral shoulders, and bilateral elbows. There was a positive Tinel's test over the bilateral cubital tunnels. There was diminished sensation to pinprick to the whole right upper extremity and along the long and small fingers of the left hand. There was numbness to pinprick on both sides of her face. There was tenderness over the bilateral shoulders including the AC joints. There was guarding and stiffness in the low back and a positive bilateral straight leg raise. There was diminished sensation to the whole right lower extremity, especially the anterior right knee, medial leg, and lateral right foot. The diagnoses were cervical spondylosis C5-6 greater than C6-7, cervical radiculopathy, low back pain, right sciatica, carpal tunnel syndrome, ulnar neuropathy, adhesive capsulitis of the bilateral shoulders, chondromalacia of the right knee, and thoracic outlet syndrome. Prior therapy included surgery. The provider recommended a cold therapy unit because the most effective method of diminishing her right upper extremity pain is ice packs. The request for authorization form was not included in the medical documents for review.

IMR ISSUES, DECISIONS AND RATIONALES

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

Chest x-ray: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pulmonary, X-ray.

Decision rationale: The request for a chest x-ray is non-certified. California MTUS recommend x-ray for acute cardiopulmonary findings by history/physical or chronic cardiopulmonary disease in the elderly over 65. Routine test radiographs are not recommended in asymptomatic patients with unremarkable history and physical. A chest x-ray is typically the first imaging test used to help diagnose symptoms such as shortness of breath or persistent cough, chest pain or injury, and fever. There are no signs and symptoms or diagnosis congruent with the guideline recommendation of a chest x-ray. As such, the request for Chest x-ray is not medically necessary.

PT 2 x3 weeks: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine, page(s) 9 Page(s): 9.

Decision rationale: California MTUS states that active therapy is based on the philosophy that therapeutic exercise and/or activity are beneficial for restoring flexibility, strength, endurance, function, and range of motion and can alleviate discomfort. Active therapy requires an internal effort by the individual to complete a specific exercise or task. Injured workers are instructed and expected to continue active therapies at home as an extension of the treatment process in order to maintain improvement levels. There was a lack of documentation indicating the injured worker's prior course of physical therapy, as well as the efficacy of the prior therapy. The guidelines recommend up to 10 visits of physical therapy; the amount of physical therapy visits that have already been completed were not provided. Additionally, injured worker's are instructed and expected to continue active therapies at home; there are no significant barriers to transitioning the injured worker to an independent home exercise program. The provider's request does not indicate the site that the physical therapy visit is intended for in the request as submitted. As such, the request for Physical Therapy is not medically necessary.

Cold therapy unit: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Knee and Leg, Cryotherapy.

Decision rationale: Official Disability Guidelines recommend continuous-flow cryotherapy as an option after surgery for up 7 days, including home use. The request for 1 cold unit exceeds the recommendations of the guidelines. It is not clear if the request was for the purchase or rental of the unit and the medical documents provided do not indicate the medical need for the cryotherapy unit that would fall within the guideline limitations such as surgery. Additionally, the site that the cold therapy unit was intended for was not provided. As such, the request for Cold Therapy Unit is not medically necessary.