MAXIMUS Federal Services

Case Number:	CM14-0051126		
Date Assigned:	06/23/2014	Date of Injury:	12/08/1998
Decision Date:	09/11/2014	UR Denial Date:	02/24/2014
Priority:	Standard	Application Received:	03/20/2014

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 injured worker is a 52 year-old female who was reportedly injured on December 8, 1998. The mechanism of injury is not listed in these records reviewed. The most recent progress note dated November 19, 2013, indicates that there are ongoing complaints of back pain and "fragmented sleep". The physical examination demonstrated no specific findings. There was an emergency room evaluation in September, 2013 noting a 24-hour exacerbation of right low back pain. This episode was treated with intramuscular Dilaudid and Valium. Diagnostic imaging studies objectified no intra-articular pathology in the left shoulder. A tendinosis of the right shoulder was noted. Previous treatment includes lumbar fusion surgery, multiple medications, multiple magnetic resonance images of various body parts, the functional capacity evaluation. A request had been made for aquatic therapy, acupuncture, a sleep study, a cold therapy unit, interferential unit for purchase, occipital block injections and was not certified in the pre-authorization process on February 24, 2014.

IMR ISSUES, DECISIONS AND RATIONALES

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

Aquatic Therapy 3x4 12 units: 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 8 C.C.R. 9792.20 - 9792.26 MTUS (Effective July 18, 2009) Page 22 of 127 Page(s): 22.

Decision rationale: When noting the date of injury, the injury sustained, the treatment rendered, the emergency room evaluations and the parameters outlined in the California Medical Treatment Utilization Schedule, there is insufficient clinical evidence presented to support this request. There is no narrative outlining why land-based therapy (in this case are home-based protocol) cannot be utilized to address the sequelae of the lumbar injury and fusion surgery. When noting the amount of therapy order completed, there is actually no information presented to establish aquatic therapy protocol therefore the request for Aquatic Therapy 3x4 12 units is not medically necessary and appropriate.

Acupuncture 3x4 12 units: Upheld

Claims Administrator guideline: Decision based on MTUS Acupuncture Treatment Guidelines.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines 8 C.C.R. 9792.20 - 9792.26 MTUS (Effective July 18, 2009) Page 13 of 127.See Section 9792.24.1 of the California Code of Regulations, Title 8, under the Special Topics section. This section addresses the use of acupuncture for chronic pain in the workers' compensation system in California Page(s): 13.

Decision rationale: When noting the date of injury, the injury sustained, the treatment rendered, and the parameters outlined in the California Medical Treatment Utilization Schedule, it is noted that acupuncture is used as an option when pain medication is reduced or not tolerated. There is no discussion in the progress notes reviewed to suggest any reduction in pain medication, increase functionality or that this intervention should be accomplished this many years subsequent to the date of injury. Therefore, based on the limited clinical ration presented for review this is not medically necessary and appropriate.

Sleep Study: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) chronic pain chapter updated July, 2014.

Decision rationale: Official Disability Guidelines support Polysomnography for excessive daytime somnolence, cataplexy, morning headaches, intellectual deterioration, personality changes, sleep-related breathing disorder or periodic limb movement disorder and insomnia for 6 months that is unresponsive to behavioral intervention and sedative/sleep-promoting medications and psychiatric etiology has been excluded. After review of the available medical records, the

injured worker does not meet the criteria due to lack of supporting clinical documentation. As such, this request is considered not medically necessary.

Lumbar Brace: Upheld

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

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

Decision rationale: Treatment guidelines do not support the use of lumbar sacral orthotics and 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. The lack of support for these devices in a subacute and chronic pain setting is based on the decreased activity level and weakness created by the device itself affecting all levels of the lumbar and sacral spine, with further resultant weakness and decreased mobility. Based on the guideline recommendations and the information provided for the above noted request is considered not medically necessary.

Hot/Cold Therapy Unit: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation (ODG) Official Disability Guidelines Continuous-flow cryotherapy-Knee and Leg Chapter.

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.

Interferential Unit for purchase: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation (ODG) Official Disability Guidelines Interferential current therapy (IFC)-Knee and Leg Chapter.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines 8 C.C.R. 9792.20 - 9792.26. MTUS (Effective July 18, 2009) Page 113 - 116 of 127 Page(s): 113-116 OF 127.

Decision rationale: Physical modalities such as transcutaneous electrical nerve stimulations have no proven efficacy in treating acute low back symptoms. Insufficient scientific testing exists to determine the effectiveness of these therapies, but they may have some value in the short term if used in conjunction with a program of functional restoration. Therefore, based on the limited medical records presented for review this is not medically necessary.

Occipital Block injections including pre-ops: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation (ODG) Official Disability Guidelines Greater occipital nerve block (GONB)-Head Chapter.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines CHAPTER ISSUE Page(s): 102.

Decision rationale: When noting the date of injury, the injury sustained, the treatment to date, and the lack of any specific clinical information is indicating any particular lesion involving the occipital nerve, there is no data presented support this request. Therefore, this is not medically necessary.

Followup with [redacted]: Overturned

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines 8 C.C.R. 9792.20 - 9792.26 MTUS (Effective July 18, 2009) Page 78 of 127 Page(s): 78 OF 127.

Decision rationale: When noting the date of injury, the injury sustained, the surgical intervention completed and the ongoing multitude of complaints; there is a clinical indication for a follow-up evaluation. At that time a complete, comprehensive and thorough history and narrative to establish the treatment plan should be accomplished so that there is a clear understanding of the current clinical situation and the clinical indication for any requested interventions so this is medically necessary.