MAXIMUS Federal Services

Case Number:	CM14-0060354		
Date Assigned:	08/08/2014	Date of Injury:	06/19/2011
Decision Date:	09/24/2014	UR Denial Date:	04/07/2014
Priority:	Standard	Application Received:	05/01/2014

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 36 year old female was reportedly injured on June 19, 2011. The mechanism of injury is noted as lifting a heavy metal container. The most recent progress note, dated February 28, 2014, indicates that there are ongoing complaints of bilateral hand and wrist pain. The physical examination demonstrated tenderness over the bilateral hands with spasms and decreased range of motion, positive Tinel's and negative Phalen's test, lumbar spine revealed slightly reduced range of motion and a negative straight leg test, and normal lower extremity neurological examination. Diagnostic imaging studies of the right hand show a bony cyst within the fifth metacarpal. An MRI of the left hand showed a 2 millimeter region of avascular necrosis along the ulnar articular surface of the lunate. Previous treatment includes physical therapy, meds/cold packs, massage, electro treatments, and oral medications. A request was made for chiropractic care, physical therapy, acupuncture for the lumbar spine twice week for four weeks, a functional capacity evaluation, a muscle stimulator, and aqua relief system for the lumbar spine, a home exercise kit for the lumbar spine, as well as Electromyography (EMG) nerve conduction velocity (NCV) testing for the lumbar spine and was not certified in the preauthorization process on April 14, 2014.

IMR ISSUES, DECISIONS AND RATIONALES

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

Chiro Lumbar Spine 2 times a week for 4 weeks: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines 8 C.C.R. 9792.20 - 9792.26; Page(s): 58-59 OF 127.

Decision rationale: The California Medical Treatment Utilization Schedule (MTUS) guidelines support the use of manual therapy and manipulation (chiropractic care) for low back pain as an option. A trial of six visits over two weeks with the evidence of objective functional improvement, and a total of up to eighteen visits over sixteen weeks is supported. After review of the available medical records, there is no clinical documentation or baseline level of function to show future subjective or objective improvements with the requested treatment. In addition, eight visits requested exceed the six visits of an initial trial period. Furthermore it is unclear why there are concurrent requests for physical therapy, chiropractic care, and acupuncture. For these reasons, this request for chiropractic care for the lumbar spine twice a week for four weeks is not medically necessary.

Physical Therapy Lumbar Spine 2 times a week for 4 weeks: Upheld

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

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

Decision rationale: A review of the medical records indicates that the injured employee has already participated in physical therapy with unknown efficacy. Additionally it is unclear why there is a concurrent request for physical therapy, chiropractic care, and acupuncture. For these reasons, this request for physical therapy twice a week for four weeks for the lumbar spine is not medically necessary.

Acupuncture Lumbar Spine 2 times a week for 4 weeks: 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; Page(s): 13 OF 127.

Decision rationale: According to the California Chronic Pain Medical Treatment Guidelines acupuncture treatments should be assessed after three to six visits to assess efficacy. This request is for eight visits. Furthermore it is unclear why there are concurrent requests for physical therapy, chiropractic care, and acupuncture. For these reasons, this request for acupuncture twice week for four weeks is not medically necessary.

Functional Capacity Evaluation for Lumbar Spine: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation American College of Occupational and Environmental Medicine (ACOEM): Independent Medical Examinations and Consultations; Referral Issues and the Independent Medical Examination Process (electronically cited).

Decision rationale: American College of Occupational and Environmental Medicine (ACOEM) practice guidelines, support the use of functional capacity evaluations (FCE) when necessary to translate medical evidence of functional limitations to determine work capability. The Official Disability Guideline (ODG) details the recommendation to consider a functional capacity evaluation (FCE) if the patient has evidence of prior unsuccessful return to work attempts or there is conflicting medical reporting on precautions and/or fitness for a modified job or if the patient's injuries are such that require a detailed exploration of the workers abilities. A review of the available medical records does not indicate if the injured employee has tried to return to work or not. As such, this request for a functional capacity evaluation is not medically necessary.

Muscle Stimulator: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines 8 C.C.R. 9792.20 - 9792.26; Page(s): 117-118 OF 127.

Decision rationale: According to the California Chronic Pain Medical Treatment Guidelines the use of an H wave stimulator is recommended for chronic soft tissue inflammation as an adjunct to evidence based functional restoration only following the failure of initially recommended conservative care to include physical therapy, medications, and the use of a tens unit. Injured employee has precipitous page in physical therapy but the efficacy of this is unknown additionally there has been no usage of a transcutaneous electrical nerve stimulation (TENS) unit. For these reasons, this request for muscle stimulators is not medically necessary.

Aqua Relief System for Lumbar Spine: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Aetna Clinical Policy Bulletin: Cryoanalgesia and Therapeutic Cold.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation Low Back - Lumbar and Thoracic, Cold/Heat Packs.

Decision rationale: According to the Official Disability Guidelines (ODG), cold is only recommended for the first few days after an acute injury and thereafter heat should be apply.

Considering this, a device for continuous cold or hot usage is not justified. Therefore this request for aqua relief system for the lumbar spine is not medically necessary.

Home Excercise Kit for Lumbar Spine: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Low Back - Lumbar and Thoracic, Exercise.

Decision rationale: According to the Official Disability Guidelines (ODG), a home exercise program is recommended for the lumbar spine, however it is unclear why there is a request for additional equipment for this. Without additional clarification of what is included in a home exercise kit and why it is needed, this request for a home exercise kit for the lumbar spine is not medically necessary.

EMG for Lumbar Spine: Upheld

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

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

Decision rationale: The most recent progress note dated February 28, 2014, indicates that there is a normal lower extremity neurological examination. Considering this, it is unclear why there is a request for electromyography (EMG) studies for the lumbar spine. As such, this request for EMG studies for the lumbar spine is not medically necessary.

NCV for Lumbar Spine: Upheld

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

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

Decision rationale: The most recent progress note dated February 28, 2014, indicates that there is a normal lower extremity neurological examination. Considering this, it is unclear why there is a request for nerve conduction velocity (NCV) studies for the lumbar spine. As such, this request for NCV studies for the lumbar spine is not medically necessary.