MAXIMUS Federal Services

Case Number:	CM15-0084560		
Date Assigned:	05/11/2015	Date of Injury:	02/19/2009
Decision Date:	07/01/2015	UR Denial Date:	04/15/2015
Priority:	Standard	Application Received:	05/04/2015

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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:
State(s) of Licensure: California, Hawaii
Certification(s)/Specialty: Physical Medicine & Rehabilitation

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 58 year old, female who sustained a work related injury on 2/19/09. The diagnoses have included neck strain, low back strain and left shoulder strain. The treatments have included medications. In the PR-2 dated 10/3/14, the injured worker complains of neck pain. She rates this pain level an 8/10. She complains of low back pain. She rates this pain level an 8/10. She complains of left shoulder pain. She rates this pain level an 8/10. She states the pain medication is helpful in relieving her pain symptoms. She has tenderness to cervical paravertebral musculature. She has tenderness to palpation over posterior rotator cuff region of left shoulder. She has decreased range of motion in left shoulder. She has tenderness to palpation of lumbar paravertebral musculature. She has positive straight leg raises bilaterally. The treatment plan for this visit includes refills of medications and a urine test. There are not any more recent progress notes in the submitted medical records.

IMR ISSUES, DECISIONS AND RATIONALES

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

Physical therapy three times four for the cervical spine: Upheld

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

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

Decision rationale: The patient presents with 8/10 neck pain, 8/10 low back pain and 8/10 left shoulder pain. The current request is for Physical therapy 3 x 4 for the cervical spine. The treating physician report dated 10/3/14 is the only report provided for review. In that report there is no discussion regarding the patient requiring physical therapy. The MTUS guidelines state allow 8-10 sessions of physical therapy for myalgia and neuritis type conditions. In this case, the treating physician has documented that the patient has tenderness to palpation of the neck, back and shoulder. There is no documentation of any surgery, new injury or new diagnosis that requires physical therapy and there is no rationale as to why there would need to be treatment in excess of the MTUS guidelines. The current request is not medically necessary and the recommendation is for denial.

DME Hot and Cold Unit Purchase: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG, Low back, Cold/Heat packs.

Decision rationale: The patient presents with 8/10 neck pain, 8/10 low back pain and 8/10 left shoulder pain. The current request is for DME Hot and Cold unit purchase. The treating physician report dated 10/3/14 is the only report provided for review. In that report there is no discussion regarding the patient requiring a DME Hot and Cold unit purchase. The MTUS and ACOEM Guidelines are silent with regards to this request. However, ODG Guidelines under the Low Back chapter on Cold/Heat Packs recommends at-home, local applications of cold pack in the first few days of acute complaints; thereafter, applications of heat packs. ODG further states that mechanical circulating units with pumps have not been proven to be more effective than passive hot/cold therapy. The records do not show any specific request for a hot and cold unit. The report making the request was not made available. In this case, the ODG guidelines do not recommend mechanical circulating units over passive hot/cold therapy. The current request is not medically necessary and the recommendation is for denial.

Physical therapy three times four for the lumbar spine: Upheld

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

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

Decision rationale: The patient presents with 8/10 neck pain, 8/10 low back pain and 8/10 left shoulder pain. The current request is for Physical therapy 3 x 4 for the lumbar spine. The treating physician report dated 10/3/14 is the only report provided for review. In that report there

is no discussion regarding the patient requiring physical therapy. The MTUS guidelines state allow 8-10 sessions of physical therapy for myalgia and neuritis type conditions. In this case, the treating physician has documented that the patient has tenderness to palpation of the neck, back and shoulder. There is no documentation of any surgery, new injury or new diagnosis that requires physical therapy and there is no rationale as to why there would need to be treatment in excess of the MTUS guidelines. The current request is not medically necessary and the recommendation is for denial.

Lumbar support: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG).

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 301. Decision based on Non-MTUS Citation ODG Low Back Chapter lumbar supports.

Decision rationale: The patient presents with 8/10 neck pain, 8/10 low back pain and 8/10 left shoulder pain. The current request is for Lumbar support. The treating physician report provided does not request a lumbar support brace. The ACOEM guidelines state: "Lumbar supports have not been shown to have any lasting benefit beyond the acute phase of symptom relief." and "There is no evidence for the effectiveness of lumbar supports in preventing back pain in industry." The ODG guidelines state, "ODG Low Back Chapter Treatment: Recommended as an option for compression fractures and specific treatment of spondylolisthesis, documented instability, and for treatment of nonspecific LBP (very low-quality evidence, but may be a conservative option)." In this case, there is no medical rationale provided to indicate that that patient requires a lumbar support. There are no objective findings in the documents available for review that support use of a brace and the patient does not present with any of the criteria set forth in the ODG guidelines. Therefore, the current request is not medically necessary and the recommendation is for denial.