MAXIMUS Federal Services

Case Number:	CM14-0119958		
Date Assigned:	08/08/2014	Date of Injury:	07/09/2013
Decision Date:	10/07/2014	UR Denial Date:	06/30/2014
Priority:	Standard	Application Received:	07/30/2014

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 Texas. 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:

Medical records reflect this claimant is a 42 year old female who sustained a work injury on 7-9-13. On this date, the claimant fell from the top of a machine and hit her body against steps. As she was falling, she grabbed and held onto the metal rail and she twisted her body and cut her right pinky finger. The claimant is being treating for chronic pain in the cervical spine, lumbar spine, shoulders and right wrist and little finger. Office visit from 4-9-14 notes the claimant has no antalgic gait, tenderness to palpation at the cervical spine and trapezius, painful range of motion of the cervical spine and left shoulder, tenderness over the ventral surface of the right wrist, painful wrist range of motion, tenderness over the lumbar spine and painful range of motion of the lumbar spine. DTR are +2 bilaterally in the upper and lower extremities. The claimant has been treated with physical therapy and medications. The claimant reported she began to develop depression due to her injury.

IMR ISSUES, DECISIONS AND RATIONALES

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

Diathermy, massage, EMS and Ultrasound two (2) times five (5) QTY: 10.00: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 173-174,Chronic Pain Treatment Guidelines Massage therapy/NMES/ Page(s): 60, 121. Decision based on Non-MTUS Citation Work Loss Data Institute; Official Disability Guidelines (ODG) Treatment in Workers' Compensation, 12th

Edition, 2014, Neck Chapter (6/30/2014)/Low back Chapter (10/16/12)/Chronic Pain Chapter (3/3/14)

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) pain chapter: EMS, US, massage. Low back chapter: Cold packs

Decision rationale: ODG reflects that therapeutic ultrasound is not recommended. Therapeutic ultrasound is one of the most widely and frequently used electrophysical agents. Despite over 60 years of clinical use, the effectiveness of ultrasound for treating people with pain, musculoskeletal injuries, and soft tissue lesions remains questionable. ODG reflects that massage should be an adjunct to other recommended treatment (e.g. exercise), and it should be limited to 4-6 visits in most cases. ODG reflects that neuromuscular electrical stimulation is not recommended. ODG reflects that cold packs Recommended as an option for acute pain. At-home local applications of cold packs in first few days of acute complaint; thereafter, applications of heat packs or cold packs. Based on the records provided, there is an absence in documentation to support the modalities being requested. This claimant has participated in physical therapy in the past and there is absence in the literature to support massage as an isolated intervention, the use of US and EMS at this juncture so far removed from the original injury and as isolated treatment modalities. The use of cold packs does not require specialized equipment and can be easily performed at home. Therefore, the medical necessity of this request is not established as reasonable or medically indicated.

Chiropractic sessions two (2) times five (5) QTY: 10.00: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 173,Chronic Pain Treatment Guidelines Manual therapy & manipulation Page(s): 58. Decision based on Non-MTUS Citation Work Loss data Institute; Official Disability Guidelines (ODG) Treatment in Workers' Compensation, 11th Edition 2013, Neck and Upper back Chapter (3/20/13)

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines manipulation Page(s): 58.

Decision rationale: Chronic Pain Medical Treatment Guidelines as well as ODG reflect that manipulation and manual therapy is recommended for chronic pain if caused by musculoskeletal conditions. However, this claimant has been provided with physical therapy in the past without quantification and documentation of functional improvement. Additionally, there is an absence in documentation noting that this claimant cannot perform a home exercise program based on the physical therapy she has had in the past. Therefore the medical necessity of this request is not established.

Magnetic Resonance Imaging (MRI) lumbar spine: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303.

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), 2nd Edition, (2004) Lumbar spine chaper - diagnostic investigations - MRI Official Disability Guidelines (ODG) low back chapter - MRI

Decision rationale: ACOEM notes that MRI is moderately recommended for patients with subacute or chronic radicular pain syndromes lasting at least 4 to 6 weeks in whom the symptoms are not trending towards improvement. ODG recommends an MRI if there are progressive neurological deficits. Upon review of the documentation provided, there is an absence in documentation noting that this claimant has neurological deficits. She is intact neurologically. There is an absence in objective data to support a nerve root compression. Therefore, the medical necessity of this request is not established.

Magnetic Resonance Imaging (MRI) cervical spine: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 182.

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), 2nd Edition, (2004) cervcial spine - diagnostic investigations - MRI Official Disability Guidelines (ODG) neck and upper back chapter - MRI

Decision rationale: ACOEM notes that MRI is recommended if there is progressive neurologic deficit, significant trauma with no improvement in significantly painful or debilitating symptoms, a history of neoplasia (cancer), multiple neurological abnormalities that span more than one neurological root level, previous neck surgery with increasing neurologic symptoms, fever with severe cervical pain; or symptoms or signs of myelopathy. ODG recommends an MRI if there are progressive neurological deficits. Upon review of the documentation provided, there is an absence in documentation noting that this claimant has neurological deficits or any of the above criteria's. She is intact neurologically. There is an absence in objective data to support a nerve root compression. Therefore, the medical necessity of this request is not established.

Magnetic Resonance Imaging (MRI) right shoulder: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 207.

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), 2nd Edition, (2004) shoulder chapter - diagnostic investigations - MRI Official Disability Guidelines (ODG) shoulder chapter- MRI

Decision rationale: ACOEM notes that MRI is recommended for patients suspected of having acute, clinically significant rotator cuff tears. It is also recommended for select patients with

subacute or chronic shoulder pain thought to potentially have a symptomatic rotator cuff tear. ODG notes that an MRI is recommended if there is an acute shoulder trauma, suspect rotator cuff tear/impingement; over age 40; normal plain radiograph, subacute shoulder pain, suspect instability/labral tear. There is an absence in objective exam findings to support the suspicion of a shoulder rotator cuff tear or labral tear/instability. Therefore, based on the records provided, the medical necessity of this request is not established.

Magnetic Resonance Imaging (MRI) left shoulder:

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 207.

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), 2nd Edition, (2004) shoulder chapter - diagnostic investigations - MRI Official Disability Guidelines (ODG) shoulder chapter- MRI

Decision rationale: ACOEM notes that MRI is recommended for patients suspected of having acute, clinically significant rotator cuff tears. It is also recommended for select patients with subacute or chronic shoulder pain thought to potentially have a symptomatic rotator cuff tear. ODG notes that an MRI is recommended if there is an acute shoulder trauma, suspect rotator cuff tear/impingement; over age 40; normal plain radiograph, subacute shoulder pain, suspect instability/labral tear. There is an absence in objective exam findings to support the suspicion of a shoulder rotator cuff tear or labral tear/instability. Therefore, based on the records provided, the medical necessity of this request is not established.

Computerized range of motion C/S,L/S, Upper extremities: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Work Loss Data Institute; Official Disability Guidelines (ODG), 12th Edition 2014, Low Back Chapter (6/11/14)/Neck Chapter (6/11/14), Computerized range of motion (ROM)

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) low back chapter - computerized range of motion testing

Decision rationale: ODG reflects that computerized range of motion testing is not recommended as primary criteria, but should be a part of a routine musculoskeletal evaluation. The relation between lumbar range of motion measures and functional ability is weak or nonexistent. There is an absence in documentation and in the current medical literature to support that computerized range of motion testing is superior to a thorough physical exam which is part of a routine office visit. Therefore, based on the records provided, this request is not established as medically indicated.

Physical Therapy two (2) times a week times twelve (12) weeks QTY: 24.00: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical medicine guidelines Page(s): 99. Decision based on Non-MTUS Citation Work Loss data Institute; Official Disability Guidelines (ODG) Treatment in Workers' Compensation 9th Edition, 2011, Physical Therapy Guidelines

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Page(s): 98-99. Decision based on Non-MTUS Citation Official Disability Guidelines physical medicine

Decision rationale: Chronic Pain Medical Treatment Guidelines as well as ODG notes that one should allow for fading of treatment frequency (from up to 3 visits per week to 1 or less), plus active self-directed home Physical Medicine. The claimant had been provided with physical therapy. There is an absence in documentation noting that this claimant cannot perform a home exercise program. This claimant should already be exceeding well-versed in an exercise program. It is not established that a return to supervised physical therapy is medically necessary and likely to significantly improve or impact the patient's overall pain level and functional status beyond that of her actively utilizing an independent home exercise program. The guidelines state patients are instructed and expected to continue active therapies at home as an extension of the treatment process in order to maintain improvement levels. The requested course of physical therapy is excessive and inconsistent with the recommendations of the CA MTUS guidelines. The medical necessity of the request is not established.