

Case Number:	CM14-0149887		
Date Assigned:	09/18/2014	Date of Injury:	12/01/2006
Decision Date:	10/17/2014	UR Denial Date:	09/05/2014
Priority:	Standard	Application Received:	09/15/2014

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, has a subspecialty in Interventional Spine 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 patient is a 62 years old female with an injury date on 12/01/2003. Based on the 08/21/2014 progress report provided by [REDACTED], the diagnoses are: 1.Cervical spondylosis without Myelopathy 2.Lumbar spondylosis without Myelopathy 3.Chondromalacia Patella of the right knee According to this report, the patient complains of constant severe neck pain and low back pain that are sharp. Prolonged walking and prolonged sitting would aggravate the low back pain. The pain radiates down into the right buttock. The patient also complains of intermittent moderate to severe right knee pain. Physical exam reveals tenderness and spasm at the bilateral cervical paraspinals muscles, bilateral suboccipital muscles, bilateral upper shoulder muscles, bilateral lumbar paraspinals muscles, and the multifidus muscle. Ranges of motion of the cervical and lumbar spine are restricted due to pain. Axial compression, cervical distraction, shoulder depression test, Kemp's test, and Yeoman's test are positive, bilaterally. Exam of the knee reveals tenderness at the right anterior joint line with restricted range of motion. Grinding test is positive on the right. There were no other significant findings noted on this report. The utilization review denied the request on 09/05/2014. [REDACTED] is the requesting provider, and he provided treatment report dated 08/21/2014.

IMR ISSUES, DECISIONS AND RATIONALES

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

Physical Medicine Program (electrical muscle stimulation, infrared, chiropractic manipulative therapy, massage, therapeutic activities), QTY: 12: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Therapy , Physical Medicine Guidelines, Massage in Chronic Pain, Manual Therapy and Manipulation.

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

Decision rationale: According to the 08/21/2014 report by [REDACTED] this patient presents with constant severe neck pain, low back pain that are sharp and right knee pain. The treater is requesting Physical medicine program (electrical muscle stimulation, infrared, chiropractic manipulative therapy, massage, therapeutic activities) Qty: 12. For physical medicine, the MTUS guidelines recommend for myalgia and myositis type symptoms 9-10 visits over 8 weeks. Review of available records show no therapy reports and there is no discussion regarding the patient's progress. If the patient did not have any recent therapy, a short course of therapy may be reasonable for declined function or a flare-up of symptoms. However, the treater does not discuss the patient's treatment history nor the reasons for requested additional therapy. No discussion is provided as to why the patient is not able to perform the necessary home exercises. MTUS page 8 requires that the treater provide monitoring of the patient's progress and make appropriate recommendations. In addition, the current request exceeds MTUS guidelines and the request is not medically necessary.

E-Stim lead wires and patches: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Page(s): 235, 300.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Interferential Current Stimulation ;Microcurrent electrical stimulation (MENS devices); Neuromus.

Decision rationale: According to the 08/21/2014 report by [REDACTED] this patient presents with constant severe neck pain, low back pain that are sharp and right knee pain. The treater is requesting E-stim lead wires and patches. The MTUS guidelines do not support the use of E-stim, or NMES except for stroke rehab. This patient presents with chronic neck and low back pain. The request is not medically necessary.

Follow up with range of motion measurements: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation State of California Workers' Compensation Official Medical Fee Schedule

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Interferential Current Stimulation (ICS) Page(s): 118-120.

Decision rationale: According to the 08/21/2014 report by [REDACTED] this patient presents with constant severe neck pain, low back pain that are sharp and right knee pain. The treater is

requesting follow up with range of motion measurement but the treating physician's report and request for authorization containing the request is not included in the file. Per MTUS guidelines, the treater must monitor the patient and provide appropriate treatment recommendations. Range of motion measurement is part and parcel of office examination. There is no need for any additional specialized testing. The request is not medically necessary.

Functional capacity evaluation: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation MTUS American College of Occupational and Environmental Medicine (ACOEM) Practice Guidelines, page(s) 137-138

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) Chapter 7, page(s) 137-139.

Decision rationale: According to the 08/21/2014 report by [REDACTED] this patient presents with constant severe neck pain, low back pain that are sharp and right knee pain. The treater is requesting Functional Capacity evaluation but the treating physician's report and request for authorization containing the request is not included in the file. Regarding Functional/Capacity Evaluation, ACOEM Guidelines page 137 states, "The examiner is responsible for determining whether the impairment results in functional limitations... The employer or claim administrator may request functional ability evaluations... These assessments also may be ordered by the treating or evaluating physician, if the physician feels the information from such testing is crucial...There is little scientific evidence confirming that FCEs predict an individual's actual capacity to perform in the workplace." In this case, the treater does not explain why FCE is crucial. It is not requested by the employer or the claims administrator. The FCE does not predict the patient's actual capacity to perform in the workplace. The request is not medically necessary.

Retrospective request for range of motion: 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 Page(s): 8.

Decision rationale: According to the 08/21/2014 report by [REDACTED] this patient presents with constant severe neck pain, low back pain that are sharp and right knee pain. The treater is requesting a retrospective request for range of motion evaluation but the treating physician's report and request for authorization containing the request is not included in the file. Per MTUS guidelines, the treater must monitor the patient and provide appropriate treatment recommendations. Range of motion measurement is part and parcel of office examination. There is no need for any additional specialized testing. The request is not medically necessary.