

Case Number:	CM14-0093669		
Date Assigned:	09/22/2014	Date of Injury:	12/10/2010
Decision Date:	10/21/2014	UR Denial Date:	06/04/2014
Priority:	Standard	Application Received:	06/20/2014

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, 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 51-year-old female with a date of injury of 12/10/2010. The listed diagnoses per [REDACTED] are: 1. Status post trauma secondary to fall, rule out disk herniation, cervical spine. 2. Rule out disk herniation, lumbar spine. According to progress report 04/17/2014, the patient presents with neck, bilateral arm, wrist, fingers, back, and leg pain. Examination of the cervical spine revealed painful range of motion and weakness in the bilateral upper extremities. There was decreased sensation at C5- C7 distribution. Examination of the shoulder revealed equivocal Hawkins and Neer's test bilaterally. Examination of the wrist and hands revealed equivocal Phalen's and Tinel's test but negative Finkelstein's test. Examination of the lower back revealed decreased sensation in the L5-S1 distribution bilaterally. There was unequivocal straight leg raise in the sitting position and supine position. The request is for functional restoration and manual therapy 3 times a week for 4 weeks, EMS and infrared 3 times a week for 4 weeks, and outcome assessment 1 time per month. Utilization review denied the request on 06/04/2014.

IMR ISSUES, DECISIONS AND RATIONALES

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

Functional restoration and manual therapy 3 times a week for 4 weeks: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Manual therapy & manipulation, low back.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Manual therapy & manipulation Page(s): 58,59.

Decision rationale: This patient presents with neck, bilateral arm, wrist, fingers, back, and leg pain. The treater is requesting a functional restoration and manual therapy 3 times a week for 4 weeks. The MTUS Guidelines on manual therapy and treatments page 58 and 59 recommends this treatment for chronic pain if caused by musculoskeletal conditions. A trial of 6 visits over 2 weeks and with evidence of objective functional improvement, up to 18 visits over 6 to 8 weeks is recommended. In this case, it is unclear as to when and how many chiropractic treatments were received thus far. It is clear that the patient has participated in prior treatment without documentation or discussion of functional improvement from these treatments. Labor Code 9792.20(e) defines functional improvement as significant improvement in ADLs, a reduction in work restrictions, and decreased dependence on medical treatment. Given the lack of documented functional improvement from prior chiropractic treatments, the request is not medically necessary.

EMS and infrared 3 times a week for 4 weeks: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Manual therapy & manipulation Page(s): 58,59.

Decision rationale: This patient presents with neck, bilateral arm, wrist, fingers, back, and leg pain. The treater is requesting EMS and infrared 3 times a week for 4 weeks. The MTUS, ACOEM, and ODG Guidelines do not have any discussion "EMS and Infrared" specifically. However, for neuromuscular electrical stimulation, the MTUS Guidelines page 121 has the following "Not recommended. NMES is used primarily as part of a rehabilitation program following stroke and there is no evidence to support its use in chronic pain. There is no intervention trial suggesting benefit from NMES for chronic pain." In this case, there is no indication that this patient has had a stroke. Furthermore, the treater does not discuss how this treatment is intended to treat or relieve the patient's symptoms. The requested Neuro-stimulation therapy is not medically necessary.

Outcome assessment one time per month: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Functional improvement measures.

Decision rationale: This patient presents with neck, bilateral arm, wrist, fingers, back, and leg pain. The treater is requesting outcome assessment 1 time per month. The medical file provided for review does not discuss the rationale or specifics of this request. The ACOEM, MTUS and ODG guidelines do not specifically discuss "outcome assessments." ODG under Range of Motion/flexibility has the following, "Not recommended as a primary criteria, but should be a part of a routine musculoskeletal evaluation." ODG guidelines consider examination such as range of motion, flexibility test etc. part of routine musculoskeletal evaluation. Outcome assessments should be part of examination performed during office visitation. The request is not medically necessary.