MAXIMUS Federal Services

Case Number:	CM14-0095836		
Date Assigned:	07/25/2014	Date of Injury:	05/29/2012
Decision Date:	10/08/2014	UR Denial Date:	05/30/2014
Priority:	Standard	Application Received:	06/24/2014

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 Anesthesiology, has a subspecialty in Pain Medicine and is licensed to practice in Florida. 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 injured worker is a 41-year-old male who reported an injury on 05/29/2012. The mechanism of injury was noted to be a motor vehicle accident. His diagnoses were noted to be cervical spine radiculitis, lumbar spine fusion (2 levels), and piriformis syndrome on the right. Prior treatments included an unknown number of physical therapy sessions. Diagnostic studies were not provided. Prior surgical history included a right shoulder arthroscopy/subacromial decompression and lumbar spine fusion. The clinical evaluation on 01/21/2014 noted the injured worker to have complaints of low back pain. He stated his right shoulder was better and that he was able to sleep more at night without pain. He rated his pain as a 5/10 to 6/10. Examination of the lumbar spine revealed significant tenderness of the level of L4 to S1 particularly on the left side and there was moderate tenderness of the left sacroiliac joint. He was moderately restricted in all ranges of motion of the low back secondary to pain. Examination of the right shoulder noted pain with resisted ranges of motion in all planes but no significant motor weakness. Examination of the cervical spine revealed pain with cervical compression. Current medications were not provided. The treatment plan was not noted within this evaluation. The provider's rationale for the request was not provided within the review. The Request for Authorization form was also not provided within the review.

IMR ISSUES, DECISIONS AND RATIONALES

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

Physical Therapy 2 x 3, Bilateral upper Extremities,Cervical, and Lumbar: Upheld

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

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

Decision rationale: The request for physical therapy 2 x 3, bilateral upper extremities, cervical, and lumbar is not medically necessary. The California MTUS Chronic Pain Medical Treatment Guidelines recommend 9-10 visits over 8 weeks for myalgia and myositis with the fading of treatment frequency, plus active self-directed home physical medicine. The clinical evaluation provided for review fails to indicate significant functional deficits. Range of motion values and strength testing scores were not noted within the review. There is a lack of documentation regarding the injured worker's prior physical therapy to verify the number of sessions completed and functional improvements made. In addition, no physical examination findings were provided of the left shoulder to support the request for physical therapy to the bilateral upper extremities. Therefore, the request for physical therapy 2 x 3, bilateral upper extremities, cervical, and lumbar is not medically necessary.

DME Lumbar Cushion: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 2 General Approach to Initial Assessment and Documentation.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 300. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Knee, Durable medical equipment (DME)

Decision rationale: The request for DME lumbar cushion is not medically necessary. The CA MTUS/ACOEM Guidelines state lumbar supports have not been shown to have any lasting benefit beyond the acute phase of symptom relief. The Official Disability Guidelines recommend durable medical equipment generally if there is a medical need and if the device or system meets Medicare's definition of durable medical equipment. The term DME is defined as equipment which (1) can withstand repeated use, (2) is primarily and customarily used to serve as a medical purpose, (3) generally is not useful to a person in the absence of illness or injury, and (4) is appropriate for use in a patient's home. There is no indication of any significant objective findings or functional deficits to warrant the use of a lumbar cushion. The medical records submitted for review fail to indicate a rationale for a lumbar cushion. Therefore, the request for DME lumbar cushion is not medically necessary.

Acupuncture- Bilateral Upper Extremities and Cervical spine 2 x 3: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 2 General Approach to Initial Assessment and Documentation.

MAXIMUS guideline: Decision based on MTUS Acupuncture Treatment Guidelines.

Decision rationale: The request for acupuncture- bilateral upper extremities and cervical spine 2 x 3 is not medically necessary. The California MTUS Acupuncture Guidelines state acupuncture is used as an option when pain medication is reduced or not tolerated and it may be used as an adjunct to physical rehabilitation and/or surgical intervention to hasten functional recovery. The guidelines state a time to produce functional improvement of 3 to 6 treatments. The documentation submitted for review fails to indicate that pain medications were reduced or not tolerated. In addition, no objective findings were provided of the left shoulder to support the request for acupuncture to the bilateral upper extremities. As such, the request for acupuncture- bilateral upper extremities and cervical spine 2 x 3 is not medically necessary.