

Case Number:	CM14-0161135		
Date Assigned:	10/27/2014	Date of Injury:	08/22/2013
Decision Date:	03/23/2015	UR Denial Date:	08/22/2014
Priority:	Standard	Application Received:	10/01/2014

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. 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: Illinois

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 31-year-old female who reported an injury on 08/22/2013 due to cumulative trauma. Diagnoses were lumbar disc displacement with nerve impingement, tendonitis/bursitis of the bilateral hips, bursitis of the bilateral knees, and tear of medial meniscus of bilateral knees, plantar fasciitis, and pregnancy. Past treatments consisted of medications, physical therapy, and acupuncture. The injured worker had an EMG study on 05/12/2014 that revealed no evidence of lumbosacral radiculopathy, plexopathy, or peripheral nerve entrapment. The MRI dated 05/14/2014 of the right hip revealed joint fluid is physiologic. The ligamentum teres and transverse acetabular ligament are intact. There was suggestion of focal chondral labral separation of the anterosuperior labrum. No high-grade cartilage defects were visualized. The MRI of the left hip revealed joint fluid was physiologic. The ligamentum teres and transverse acetabular ligament were intact. The visualized quadriceps, hamstring, hip flexor, hip external rotator, gluteal, and abductor tendons were intact. The MRI of the lumbar spine without contrast dated 05/13/2014 revealed at the L5-S1, moderate right and mild left neural foraminal narrowing. There was a 2 mm right posterolateral disc protrusion with annular tear contacting the exiting right L5 nerve root. No canal stenosis and no nerve impingement. The physical examination dated 10/07/2014 revealed that the injured worker complained of occupational minimal pain that was described as throbbing in her head. There were complaints of bilateral hip pain, bilateral knee pain, bilateral ankle, and foot pain. There were complaints of lumbar spine pain that was described as dull. The examination of the lumbar spine revealed a +2 spasms and tenderness to the bilateral lumbar paraspinal muscles from L3-S1 and multifidus. The Kemp's

test was positive bilaterally. Yeoman's was positive bilaterally. The examination of the hips revealed a +1 spasm and tenderness to the bilateral gluteus medius muscle and bilateral tensor fasciae latae muscles. Fabere test was positive bilaterally. The examination of the knees revealed a +2 spasms and tenderness to the bilateral anterior joint line and bilateral popliteal fossa. The Valgus test was positive bilaterally. The McMurray's test was positive bilaterally. The examination of the ankles and feet revealed a +2 spasm and tenderness to the bilateral lateral malleoli and plantar fascia. It was reported that the injured worker had completed 24 physical therapy sessions to date. It was also reported that there was a request for 10 sessions of work hardening for the lumbar spine, bilateral hips, and bilateral knees. It was reported that the injured worker was participating in a home exercise program. Medications were not reported.

IMR ISSUES, DECISIONS AND RATIONALES

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

Qualified functional capacity evaluation: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ACOEM Occupational Medicine Practice Guidelines, Chapter 7, pg. 137

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation (ODG) Fitness for Duty, Functional capacity Evaluation (FCE)

Decision rationale: The decision for Qualified Functional Capacity Evaluation is not medically necessary. It was reported that the injured worker had 24 sessions of physical therapy, medications, and acupuncture. There is a request for admission to a work hardening program for 10 visits. The Official Disability Guidelines state that functional capacity evaluation is recommended prior to admission to a work hardening program, with preference for assessments tailored to a specific test or job. If a worker is actively participating in a determining the suitability of a particular job, the functional capacity evaluation is more likely to be successful. A functional capacity evaluation is not as effective when the referral is less collaborative and more directive. It is important to provide as much detail as possible about to potential job to the assessor. Job specific functional capacity evaluations are more helpful than general assessments. The report should be accessible to all the return to work participants. When to consider a functional capacity evaluation is when the case management is hampered by complex issues such as prior unsuccessful return to work attempts, conflicting medical reporting on precautions and/or fitness for modified job, injuries that require detailed exploration of a worker's abilities. Timing is appropriate when close or at MMI/all key medical reports secured, additional/secondary conditions clarified. Do not proceed with a functional capacity evaluation if the sole purpose is to determine a worker's effort or compliance. The worker has returned to work and ergonomic assessment has not been arranged. The medical guidelines state there should be a prior unsuccessful return to work attempt. Also, the medical guidelines recommend prior admission to a work hardening program with preference for assessments tailored to a specific task or job. The rationale provided did not indicate any type of specific task or job, and

there were no reports of prior unsuccessful return to work attempts. Therefore, this request is not medically necessary.

Follow-up visit: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation (ODG) Pain, Office Visit

Decision rationale: The decision for follow-up visit is not medically necessary. The Official Disability Guidelines recommend office visits for proper diagnosis and return to function of an injured worker. The need for a clinical office visit with a healthcare provider is individualized based upon a review of the patient's concerns, signs and symptoms, clinical stability, and reasonable physician judgment. As the patient's conditions are extremely varied, a set number of office visits per condition cannot be reasonably established. The determination of necessity for an office visit requires individualized case review and assessment, being ever mindful that the best patient outcomes are achieved with the eventual patient independence from the healthcare system through self care as soon as clinically feasible. The request does not indicate what kind of follow-up visit is being requested. The request does not indicate if this is a follow-up visit for her primary care physician or for a specialist. In the absence of documentation regarding the requested follow-up visit, this request is not medically necessary.

Range of motion measurement: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation (ODG) Shoulder, Range of Motion

Decision rationale: The decision for range of motion measurement is not medically necessary. The provider did not indicate how the measurement was to be reported. It was not reported if this was to be a computerized range of motion testing or standard office testing. The Official Disability Guidelines state that range of motion is recommended. Range of motion of the shoulder should always be examined in cases of shoulder pain, but an assessment of passive range of motion is not necessary if active range of motion is normal. Loss of both active and passive range of motion suggests adhesive capsulitis or glenohumeral osteoarthritis. The provider did not indicate if this was a standard in the office range of motion testing or a computerized testing. Therefore, this request is not medically necessary.

Addressing ADLs: 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 Manual Therapy Page(s): 58-59.

Decision rationale: The decision for addressing ADLs is not medically necessary. The California Medical Treatment Utilization Schedule states that manual therapy and manipulation is recommended for chronic pain if caused by musculoskeletal conditions. For the low back, therapy is recommended initially in a therapeutic trial of 6 sessions and with objective functional improvement, a total of up to 18 visits over 6 to 8 weeks may be appropriate. Treatment for flare-ups requires a need for re-evaluation of prior treatment success. Treatment is not recommended for the ankle and foot, carpal tunnel syndrome, the forearm, wrist, and hand or the knee. If chiropractic treatment is going to be effective, there should be some outward sign of subjective or objective improvement within the first 6 visits. Treatment beyond 4 to 6 visits should be documented with objective improvement in function. The maximum duration is 8 weeks and at 8 weeks, the patient should be re-evaluated. Care beyond 8 weeks may be indicated for certain chronic pain patients in whom manipulation is helpful in improving function, decreasing pain, and improving quality of life. The request submitted is unclear about addressing ADLs. It is unclear if the provider is indicating the need for manual therapy. There is a lack of documentation to indicate exactly what is being requested. Therefore, this request is not medically necessary.

Physical Medicine: Upheld

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

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

Decision rationale: The decision for physical medicine is not medically necessary. The California Medical Treatment Utilization Schedule states that physical medicine with passive therapy can provide short-term relief during the early phases of pain treatment and is directed at controlling symptoms such as pain, inflammation and swelling, and to improve the rate of healing soft tissue injuries. Treatment is recommended with a maximum of 9 to 10 visits for myalgia and myositis, and 8 to 10 visits may be warranted for treatment of neuralgia, neuritis, and radiculitis. Patients are instructed and expected to continue active therapies at home as an extension of the treatment process in order to maintain improvement levels. Home exercise can include exercise with or without mechanical assistance or resistance and functional activities with assistive devices. It was reported that the injured worker had 24 sessions of physical therapy. The injured worker is expected to have transitioned to a home exercise program. Reasons why a home exercise program was not helping to improve the injured worker in her functional improvement of activities of daily living were not indicated. There was no rationale submitted detailing a clear indication for more sessions of physical medicine. Also, the request does not indicate how many sessions of physical medicine are being requested. Therefore, the request is not medically necessary.

Electrical muscle stimulation to the lumbar spine: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 114-121.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Guidelines TENS NMES Interferential Current Stimulation, Galvanic Stimulation Page(s): 114-116.

Decision rationale: The decision for electrical muscle stimulation to the lumbar spine is not medically necessary. The California Medical Treatment Utilization Schedule recommends a 1 month trial of a TENS unit as an adjunct to a program of evidence based functional restoration for chronic neuropathic pain. Prior to the trial, there must be documentation of at least 3 months of pain and evidence that other appropriate pain modalities have been tried (including medication) and have failed. They do not recommend neuromuscular electrical stimulation (NMES devices), as there is no evidence to support its use in chronic pain. They do not recommend interferential current stimulation (ICS) as an isolated intervention. Galvanic stimulation is not recommended also. This request does not indicate what type of electrical muscle stimulation is to be indicated. The medical guidelines do not recommend neuromuscular electrical stimulation, interferential current stimulation, or galvanic stimulation. In the absence of documenting what type of electrical muscle stimulation is being requested, this request is not medically necessary.

Electrical muscle stimulation bilateral knees: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 114-121.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Guidelines TENS, NMES, Interferential Current Stimulation, Galvanic Stimulation Page(s): 114-116.

Decision rationale: The decision for electrical muscle stimulation bilateral knees is not medically necessary. The California Medical Treatment Utilization Schedule recommends a 1 month trial of a TENS unit as an adjunct to a program of evidence based functional restoration for chronic neuropathic pain. Prior to the trial, there must be documentation of at least 3 months of pain and evidence that other appropriate pain modalities have been tried (including medication) and have failed. They do not recommend neuromuscular electrical stimulation (NMES devices), as there is no evidence to support its use in chronic pain. They do not recommend interferential current stimulation (ICS) as an isolated intervention. Galvanic stimulation is not recommended also. This request does not indicate what type of electrical muscle stimulation is to be indicated. The medical guidelines do not recommend neuromuscular electrical stimulation, interferential current stimulation, or galvanic stimulation. In the absence of documenting what type of electrical muscle stimulation is being requested, this request is not medically necessary.

Hot packs to lumbar spine: Overturned

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 298-300.

Decision rationale: The decision for hot packs to the lumbar spine is medically necessary. The California ACOEM states that at home local applications of heat or cold are as effective as those performed by therapists. The medical guidelines support the use of hot packs or heat or cold as an at home therapy. Therefore, this request is medically necessary.

Massage to lumbar spine, bilateral hips and bilateral knees: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 60.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Massage Therapy Page(s): 60.

Decision rationale: The decision for massage to the lumbar spine, bilateral hips, and bilateral knees is not medically necessary. The California Medical Treatment Utilization Schedule Guidelines recommend massage therapy that is limited to 4 to 6 visits in most cases. Massage is beneficial in attenuating diffuse musculoskeletal symptoms, but beneficial effects were registered only during treatment. Massage is a passive intervention and treatment independence should be avoided. This lack of long-term benefits could be due to the short-term treatment or treatment such as these do not address the underlying causes of pain. The request does not indicate how many visits are being requested for the injured worker. The medical guidelines state 4 to 6 visits in most cases. In the absence of documentation regarding how many visits for the massage therapy to the lumbar spine, bilateral hips, and bilateral knees, this request is not medically necessary.

Therapeutic activates to lumbar spine, supine lumbar spine and mobilization: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 298-300.

Decision rationale: The decision for therapeutic activates to lumbar spine, supine lumbar spine immobilization is not medically necessary. The California ACOEM states physical modalities, such as massage, diathermy, cutaneous laser treatment, transcutaneous electrical nerve stimulation (TENS) units, percutaneous electrical nerve stimulation (PENS) units, and biofeedback had no proven efficacy in treating acute low back symptoms. Any sufficient

scientific testing exists to determine the effectiveness of these therapies, but they may have some value in the short term if used in conjunction with a program of functional restoration. Insufficient evidence exists to determine the effectiveness of sympathetic therapy, a noninvasive treatment involving electrical stimulation, also known as interferential therapy. At home, local applications of heat or cold are as effective as those performed by therapists. The request submitted does not detail a clear indication for what is being requested. There was no rationale submitted giving a detailed clear indication for therapeutic activates to the lumbar spine, supine lumbar spine immobilization. There were no other significant factors provided to justify a decision. Therefore, this request is not medically necessary.