MAXIMUS Federal Services

Case Number:	CM14-0213672		
Date Assigned:	12/31/2014	Date of Injury:	10/04/2012
Decision Date:	02/27/2015	UR Denial Date:	12/17/2014
Priority:	Standard	Application Received:	12/22/2014

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: California
Certification(s)/Specialty: Physical Medicine & Rehabn

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 72-year-old female with a date of injury of10/04/2012. According to progress report dated 11/19/2014, the patient presents with neck, midback, low back, bilateral knee, andbilateral elbow pain. In early November, the patient had a sudden increase in low back pain. She has difficulty walking and cannot walk more than 10 feet now. She was recently seen in emergency room with intensified pain. Examination of the cervical spine revealed decreased range of motion and painful range of motion with positive muscle spasm. There is positive tenderness to palpation over the cervical trapezial ridge. Examination of the lumbar spine revealed decreased and painful range of motion. Positive muscle spasm wasnoted. The patient is unable to perform range of motion as she is in a wheelchair. She cannot walk short distance without increased pain. Examination of the thoracic spine revealed positive spasm with positive interscapular pain. Examination of the bilateral knees revealed bilateral joint pain and mild swelling in the right knee. The left knee does have some bruising over the medial aspect and there is pain with range of motion noted. The listed diagnoses are: Chronic low back pain. Lumbar discogenic disease. Thoracic discogenic disease.Cervical discogenic disease. Cervical radiculopathy. Chronic cervical pain sprain/strain. Bilateral knee derangement and joint pain. The patient is currently retired retried. Treatment plan is for chiropractic treatment 2 times a week for 6 weeks, continue home exercise program, acupuncture 2 times a week for 6 weeks, walking with seat, TENS unit, lumbar brace, and Toradol injection. The utilization review deniedthe request on 12/17/2014.

IMR ISSUES, DECISIONS AND RATIONALES

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

Chiropractic treatment, twice weekly, body part unspecified QTY: 12: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Manual Therapy & manipulation Page(s): 58-59.

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

Decision rationale: This patient presents with neck, midback, low back, bilateral knee, and bilateral elbow pain. The current request is for chiropractic treatment twice weekly, body part unspecified qty. 12. For manual therapy, the MTUS Guidelines on page 59 states, "Delphi recommendations in effect incorporate 2 trials, with a total of up to 12 trial visits with a re-evaluation in the middle, before also continuing up to 12 more visits (for a total of up to 24)." The utilization review denied the request stating that there is no documentation of objective benefit from previous/recent chiropractic sessions to warrant additional treatment. The number of completed treatments to date and the objective response to treatment were not documented in the medical reports submitted for this request. According to progress report dated 11/19/2014, "Acupuncture and chiropractic treatment has helped." It appears that this patient has had some chiropractic treatments in the past. Labor code 9792.20(e) defines functional improvement as significant improvement in ADLs or reduction in work restrictions and decreased dependence on medical treatment. In this case, there is no discussion of functional improvement, decrease in pain, or return to work status to warrant additional sessions. The requested additional chiropractic treatment is not medically necessary.

Acupuncture, twice weekly, body part unspecified QTY: 12: Upheld

Claims Administrator guideline: Decision based on MTUS Acupuncture Treatment Guidelines.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines 9792.24.1. Acupuncture Medical Treatment Guidelines. Page(s): 13.

Decision rationale: This patient presents with neck, mid, low back, bilateral knee, and bilateral elbow pain. The current request is for acupuncture, twice weekly, body part unspecified qty. 12. For acupuncture, the MTUS Guidelines page 8 recommends acupuncture for pain, suffering, and for restoration of function. The recommended frequency of duration is 3 to 6 treatments for trial and with functional improvement 1 to 2 times per day with optimal duration of 1 to 2 months. The utilization review denied the request stating there is no documentation of functional improvement from prior treatment. Review of the medical file indicates that patient has completed 12 acupuncture visits which "were helping." For additional treatment, the MTUS requires functional improvement as defined by Labor Code 9792.20(e) a significant improvement in ADLs, or change in work status and reduce dependence on medical treatments.

Given the treating physician has not documented functional improvement and reduction in medical treatments, the requested additional acupuncture is not medically necessary.

Purchase of walker with seat: Overturned

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Knee & Leg, Walking Aids

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) knee chapter, walking aids.

Decision rationale: This patient presents with neck, mid, low back, bilateral knee, and bilateral elbow pain. The current request is for purchase of walker with seat. The utilization review denied the request stating that there are no examination findings that would suggest a walker with a seat would be medically necessary. The ACOEM and MTUS Guidelines do not discuss walkers with seats. The ODG Guidelines does provide a discussion of walking aids under the knee chapter. ODG Guidelines states, walking aids are "recommended, as indicated below. Almost half of the patients with knee pain possess a walking aid. Disability, pain, and age-related impairments seem to determine the need for a walking aid. Non-use is associated with less need, negative outcome, and negative evaluation of the walking aid." In this case, the patient presents with continued bilateral knee pain and reports a recent fall which has caused an exacerbation of pain. A walking aid to alleviate weight bearing and to assist an ambulation is reasonable and supported by ODG Guidelines. The requested walker with seat is medically necessary.

TENS unit, unspecified if purchase or rental: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Transcutaneous electrotherapy Page(s): 114-116.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines TENS unit..

Decision rationale: This patient presents with neck, mid, low back, bilateral knee, and bilateral elbow pain. The current request is for TENS unit, unspecified if purchase or rental. The utilization review denied the request stating that records do not identify what the patient's current functional status is or if the patient is participating in active rehabilitation program to support the requested TENS unit. This patient has been utilizing a TENS unit as early as 10/21/2013. The treating physician has documented that the patient is utilizing a TENS unit which has been "helpful." Per MTUS Guidelines page 116, TENS unit have not proven efficacy in treating chronic pain and it is not recommended as a primary treatment modality, but a 1-month home-based trial may be considered for specific diagnosis of neuropathy, CRPS, spasticity, phantom-limb pain, and multiple sclerosis. When a TENS unit is indicated, a 30-day home trial is recommended and with documentation of functional improvement, additional usage may be

indicated. In this case, the patient has utilized a TENS unit in the past which she has been helpful, but there is no documentation regarding frequency of use, magnitude in pain reduction, and functional changes with prior use of TENS unit. MTUS Guidelines allows for extended use of the unit when there is documentation of functional improvement. The requested TENS unit is not medically necessary.

Facet Block injection, bilateral L3-S1: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Low Back, Facet Block injections

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 301. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) low back chapter regarding facet.

Decision rationale: This patient presents with neck, mid, low back, bilateral knee, and bilateral elbow pain. The current request is for facet block injections, bilateral L3-S1. ACOEM guidelines do not discuss facet joint syndrome, but do support medial branch diagnostic blocks on page 301. The ODG Guidelines under the low back chapter regarding facet joint diagnostic blocks provide more detailed discussion and allows for facet diagnostic evaluation, but not therapeutic injections for facet joints. In this case, according to progress report dated 08/06/2014, "The patient has bilateral S1 radiculopathy." Examination findings from progress report dated 04/02/2014 noted "straight leg rising was positive on exam bilaterally." In this case, the patient presents with radicular symptoms and positive straight leg raise. ODG states evaluation of facet joints are recommended when radicular symptoms are not present. The requested facet block is not medically necessary.