MAXIMUS Federal Services

Case Number:	CM14-0098178		
Date Assigned:	07/28/2014	Date of Injury:	11/28/2000
Decision Date:	07/08/2015	UR Denial Date:	06/04/2014
Priority:	Standard	Application Received:	06/26/2014

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: Utah, Arkansas
Certification(s)/Specialty: Family Practice, Sports Medicine

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 55 year old female who sustained an industrial injury on 11/29/00. The mechanism of injury was unclear. She currently complains of left shoulder pain with radiation down the arm with numbness, tingling and decreased range of motion. History of surgery in 2004 (no further details available). MRI of the left hand (3/25/14) showing possible carpal tunnel syndrome; MRI of the left shoulder (3/25/14) showing osteoarthritis, tendinosis, bursitis and synovium effusion; MRI of the right shoulder (3/25/14) showing osteoarthritis, supraspinatus partial tear, tendinosis, synovium effusion, bursitis, subcortical cysts in the humeral head; MRI of the cervical spine (3/25/14) showing disc desiccation, disc herniation. The treating provider requested physical therapy to the cervical spine twice per week for four weeks; acupuncture to the cervical spine twice per week for four weeks; chiropractic sessions twice per week for four weeks; cardio-respiratory testing one tome; transcutaneous electrical nerve stimulator unit and supplies. This information was not available for review in the records presented and came from the application.

IMR ISSUES, DECISIONS AND RATIONALES

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

Physical Therapy for the Cervical Spine (8-sessions, 2 times a week for 4-weeks):
Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine. Decision based on Non-MTUS Citation Official Disability Guidelines, Neck and Upper Back.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Page(s): 98-99. Decision based on Non-MTUS Citation ODG Neck and Upper back.

Decision rationale: MTUS treatment guidelines were reviewed in regards to this specific case, and the clinical documents were reviewed. The request is for physical therapy sessions. Physical Medicine Guidelines "Allow for fading of treatment frequency (from up to 3 visits per week to 1 or less), plus active self-directed home Physical Medicine. Myalgia and myositis, unspecified (ICD9 729.1): 9-10 visits over 8 weeks. Neuralgia, neuritis, and radiculitis, unspecified (ICD9 729.2) 8-10 visits over 4 weeks. Reflex sympathetic dystrophy (CRPS) (ICD9 337.2): 24 visits over 16 weeks." The clinical documents show previous request for physical therapy, but there is no documentation that states the injured worker has completed the previous sessions. ODG Neck and Upper back recommends 9 visits over 8 weeks for Cervicalgia (Neck pain). According to the clinical documentation provided and current MTUS guidelines; Physical therapy is indicated as a medical necessity to the patient at this time.

Acupuncture for the Cervical Spine (8-sessions, 2 times a week for 4-weeks): Upheld

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

MAXIMUS guideline: Decision based on MTUS Acupuncture Treatment Guidelines.

Decision rationale: MTUS treatment guidelines were reviewed in regards to this specific case, and the clinical documents were reviewed. The request is for Acupuncture. MTUS guidelines state the following: "Acupuncture" is used as an option when pain medication is reduced or not tolerated, it may be used as an adjunct to physical rehabilitation and/or surgical intervention to hasten functional recovery. MTUS guidelines state the following: initial trial of 3-6 visits over 3 weeks. The clinical documents show previous request for physical therapy, but there is no documentation that states the injured worker has completed previous sessions. Therefore, the patient does not meet the current criteria. According to the clinical documentation provided and current MTUS guidelines; Acupuncture, as requested above, is not indicated as a medical necessity to the patient at this time.

Chiropractic Care for the Cervical Spine (8-sessions, 2 times a week for 4-weeks): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Manual Therapy & Manipulation. Decision based on Non-MTUS Citation Official Disability Guidelines, Neck and Upper Back.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Manual Therapy & Manipulation Page(s): 58-60.

Decision rationale: MTUS guidelines state the following: Manual Therapy and Manipulation recommendations. Ankle & Foot: Not recommended. Carpal tunnel syndrome: Not recommended. Forearm, Wrist, & Hand: Not recommended. Knee: Not recommended: Low back: Recommended as an option. The cervical spine is not areas that are recommended in the MTUS guidelines for manual treatment. Therefore, the patient does not meet the current criteria. According to the clinical documentation provided and current MTUS guidelines; Chiropractic manipulative treatment, is not indicated as a medical necessity to the patient at this time.

Cardio-Respiratory Testing - Autonomic Function Assessment: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation www.mayoclinic.org/medicalprofs/autonomic-testing-applications.html.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Mayo Clinic - Cardiorespiratory Testing Autonomic Function Assessment (www.mayoclinic.org).

Decision rationale: MTUS treatment guidelines are silent with regards to the above request. Other guidelines were reviewed in regards to this specific case, and the clinical documents were reviewed. The request is for autonomic function assessment. It is unclear at this time, why this test is being ordered. There is lack of documentation that the test is indicated for the patient, as the patient does not meet criteria for the testing at this time. According to the clinical documentation provided and current guidelines; autonomic function assessment is not indicated as a medical necessity to the patient at this time.

TENS Unit & Supplies (rental or purchase): Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines TENS Unit Page(s): 113-115.

Decision rationale: MTUS treatment guidelines were reviewed in regards to this specific case, and the clinical documents were reviewed. The request is for TENS unit. MTUS guidelines state the following: Not recommended as a primary treatment modality. While TENS may reflect the long standing accepted standard of care within many medical communities, the results of studies are inconclusive, the published trials do not provide parameters which are most likely to provide optimum pain relief, nor do they answer questions about long-term effectiveness. Several studies have found evidence lacking concerning effectiveness. The patient has used a TENS unit previously and there is lack of documentation for objective and functional improvement. According to the clinical documentation provided and current MTUS guidelines; A TENS unit is not indicated as a medical necessity to the patient at this time.