

Case Number:	CM15-0060803		
Date Assigned:	04/07/2015	Date of Injury:	01/12/2014
Decision Date:	06/01/2015	UR Denial Date:	03/02/2015
Priority:	Standard	Application Received:	03/31/2015

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 & 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 54 year old female who sustained an industrial injury on 01/12/2014. Diagnoses include status post left shoulder arthroscopy and decompression, cervical disc disorder with myelopathy, lumbar disc disorder with myelopathy. Treatment to date has included surgery, diagnostic studies, medications, and physiotherapy. A physician progress note dated 02/23/2015 documents the injured worker complains of right posterior shoulder and lumbar pain. Pain is rated 8 out of 10. There is palpable tenderness at the right lumbar, lumbar, left sacroiliac, right sacroiliac, upper thoracic, right cervical dorsal, right cervical, left cervical dorsal, left anterior shoulder and right anterior shoulder. She has palpable tenderness of the shoulder at the supraspinatus, deltoids, and bicipital tendons. The treatment plan is for Magnetic Resonance Imaging of the lumbar and cervical spine, and left hip. Post-operative therapy of the left shoulder due to persistent abduction less than 90 degrees, and grade 4/5 left shoulder strength. Treatment requested is for acupuncture therapy 2x3 weeks for the bilateral neck, due to a flare up, Interferential Stimulator initial 60 day rental, MRI of the cervical spine, and transfer of care to pain management specialist.

IMR ISSUES, DECISIONS AND RATIONALES

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

Acupuncture therapy 2x3 weeks for the bilateral neck: Upheld

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

MAXIMUS guideline: Decision based on MTUS Acupuncture Treatment Guidelines.

Decision rationale: According to the California MTUS Guidelines, acupuncture may be recommended as an option when pain medication is being reduced or not tolerated, or may be used as an adjunct to physical rehabilitation or surgical intervention to hasten functional recovery. There is a lack of evidence within the documentation provided that the patient's pain medication is being reduced or not tolerated, and there is a lack of evidence that this requested treatment is being used as an adjunct to physical rehabilitation or surgical intervention. Therefore, the request for Acupuncture therapy 2x3 weeks for the bilateral neck is not medically necessary.

MRI of the cervical spine: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 177-179.

Decision rationale: According to the American College of Occupational and Environmental Medicine Guidelines, imaging studies may be recommended in patients who have emergence of a red flag; physiological evidence of tissue insult or neurological dysfunction; patients who have failed to progress in a strengthening program intended to avoid surgery; or there is a need for clarification of the anatomy prior to an invasive procedure. The guidelines continue by stating that unequivocal findings that identify specific nerve compromise on the neurological examination are sufficient evidence to warrant imaging studies if symptoms persist, however, when a neurological examination is less clear, further physiologic evidence of nerve dysfunction must be obtained prior to ordering imaging studies. There is a lack of evidence within the documentation provided that the patient has unequivocal objective exam findings that identify specific nerve compromise on the neurological examination that would warrant imaging studies, and there is a lack of evidence that the patient has failed to progress in a strengthening program intended to avoid surgery. Additionally, there is no indication within the documentation that this request is being recommended for clarification of anatomy prior to an invasive procedure. Therefore, the request for an MRI of the cervical spine is not medically necessary.

Interferential Stimulator initial 60 day rental: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Interferential Current Stimulation Page(s): 118.

Decision rationale: The California MTUS Guidelines state that interferential current stimulation is not currently recommended as an isolated treatment as there is no quality evidence of effectiveness except in conjunction with recommended treatments, including return to work, exercise, and medications. The guidelines continues by stating that, while not recommended as an isolated intervention, interferential stimulation may be used as an adjunctive therapy for injured workers whose pain is ineffectively controlled due to diminished effectiveness of medications; or pain is ineffectively controlled with medications due to side effects; or there is a history of substance abuse; or significant pain from postoperative conditions that limits the ability to perform exercise programs/physical therapy; or unresponsive to conservative measures. There is a lack of evidence within the documentation that this requested treatment option is being used as an adjunct to recommended treatments to include return to work, exercise, or medication use. Additionally, there is a lack of evidence that pain is being ineffectively controlled due to the diminished effectiveness of medication or due to side effects of medications. Furthermore, there is a lack of evidence that the patient has a history of substance abuse, or significant pain from postoperative conditions limiting the injured worker's ability to perform an exercise program. Moreover, there is a lack of evidence within the documentation that the injured worker has failed to respond to other conservative treatment measures. In addition, trials are typically only recommended for 30 days. Therefore, the request for Interferential Stimulator initial 60 day rental is not medically necessary.

Transfer of care to another physician: Overturned

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 13 Knee Complaints Page(s): 341. Decision based on Non-MTUS Citation Official Disability Guidelines.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Introduction Page(s): 1. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Chapter 7.

Decision rationale: According to the California MTUS Guidelines, physicians may consider evaluation with a specialist if injured workers continue to have persistent complaints despite treatment with conservative management. Additionally, according to the American College of Occupational and Environmental Medicine Guidelines, they state that if a diagnosis is uncertain or complex, psychosocial factors are present, or if the plan or course of care may benefit from additional expertise, the physician may refer a patient to other specialists. The documentation provided indicates that the physician was recommending the patient be transferred to a pain management physician as the patient has had chronic pain for over 90 days and would require further treatment options that could be better provided by a pain management specialist. As the patient was noted to have chronic complaints of pain to the left shoulder, cervical spine, and low back despite conservative treatment to date, a transfer of care to a chronic pain management specialist would be appropriate and supported. Therefore, the request is medically necessary.