

Case Number:	CM13-0003858		
Date Assigned:	08/02/2013	Date of Injury:	05/06/2011
Decision Date:	03/25/2014	UR Denial Date:	07/17/2013
Priority:	Standard	Application Received:	07/26/2013

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 licensed in Chiropractic Services, and is licensed to practice in California. 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 physician 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:

Patient is a 32 year old female employed as a laborer who sustained a CT injury to her right shoulder from 1/1/09 to 5/10/11. The patient complains of constant pain in her right shoulder. The comprehensive orthopedic consultative report provided states that "the patient complains of burning right shoulder pain radiating down the right arm to the fingers associated with muscle spasms. She rates the pain at 6/10 on the pain analog scale. Her pain is considered as constant, moderate to severe. The pain is aggravated by gripping, grasping, reaching, pulling, lifting and doing work at or above the shoulder level." Treatment since the date of injury has included medications, acupuncture, physical therapy, massage, suction cups and chiropractic care. The diagnoses per the PTP's PR2 reports provided are shoulder bursitis, myofascitis, cervicobrachial syndrome and lumbar radiculitis. A drug test/screening was performed for pain management compliance purposes on 12/11/12. On 6/28/12 the patient was seen by a PQME and per his report provided in the records an MRI of the right shoulder was performed and revealed positive findings. An EMG/NCV study was also conducted which revealed "right C6 chronic active radiculopathy." The PTP is requesting unspecified number of CMT, EMS, ultrasound, traction and M release: therapeutic exercises to the neck, right shoulder and lower back.

IMR ISSUES, DECISIONS AND RATIONALES

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

CMT: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines manipulation and manual therapy Page(s): 58, 98-99.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines manipulation and manual therapy Page(s): 58-60.

Decision rationale: The number of visits for the requested treatments are not listed in this case. The records provided do not contain any legible documentation of the patient's treatments especially findings before, during and after the chiropractic, CMT, physical therapy, EMS , US, myofascial therapy or treatment. Exam finding provided by the orthopedic consultant and PQME detail range of motion, muscle testing, neurological exam and pain intensity. In this case, the documentation provided does show if any of the requested care was of any benefit. For the most part these records do not exist in the material provided. As for manual therapy and manipulation, Chronic Pain Treatment Guidelines p. 58-60 state that Manual therapy and Manipulation "are recommended for chronic pain if caused by musculoskeletal conditions." It also states that the "goal is to achieve positive symptomatic and/or objective measurable gains in functional improvement." This (ODG) Official Disability Guidelines Manipulation and Manual therapy section shoulder chapter also states "Allow for fading of treatment frequency (from up to 3 visits per week to 1 or less), plus active self-directed home therapy 9 visits over 8 weeks." CMT is not medically necessary.

EMS: 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 Official Disability Guidelines (ODG) neck, shoulder, low back, EMS/TENS.

Decision rationale: There is no evidence of functional improvement in the records of this evidence before and after chiropractic care. Under ODG shoulder chapter for TENS, it is recommended only "post-stroke to improve passive humeral lateral rotation, but there is limited evidence to determine if the treatment improves pain." TENS is not medically necessary.

Ultrasound: 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 Official Disability Guidelines (ODG) neck, shoulder, low back, Extracorporeal shock wave therapy.

Decision rationale: ODG shoulder section for Extracorporeal shock wave therapy states: "recommended for calcifying tendonitis. Maximum of 3 therapy sessions over 3 weeks." In this

case patient is not suffering from a calcific tendonitis of the shoulder. ODG also states in this section that "There is no evidence of benefit in non-calcific tendonitis of the rotator cuff, or other shoulder disorders, including frozen shoulder or breaking up adhesions." There are no records of any CMT, US, EMS, manual therapy that show objective functional improvement. MTUS-Definitions page 1 defines functional improvement as a "clinically significant improvement in activities of daily living or a reduction in work restrictions as measured during the history and physical exam, performed and documented as part of the evaluation and management visit billed under the Official Medical Fee Schedule (OMFS) pursuant to Sections 9789.10-9789.11; and a reduction in the dependency on continued medical treatment." Given the absence of objective functional improvement data from past treatments I find the unspecified number of treatments requested, CMT, EMS, US and M release: therapeutic exercises to the neck, right shoulder and lower back to not be appropriate and not medically necessary.

M release: therapeutic exercise for the neck, right shoulder, and low back: 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): 58-60.

Decision rationale: There are no records of any CMT, US, EMS, manual therapy that show objective functional improvement. MTUS-Definitions page 1 defines functional improvement as a "clinically significant improvement in activities of daily living or a reduction in work restrictions as measured during the history and physical exam, performed and documented as part of the evaluation and management visit billed under the Official Medical Fee Schedule (OMFS) pursuant to Sections 9789.10-9789.11; and a reduction in the dependency on continued medical treatment." Given the absence of objective functional improvement data from past treatments I find the unspecified number of treatments requested, CMT, EMS, US and M release: therapeutic exercises to the neck, right shoulder and lower back to not be appropriate and not medically necessary.

Traction: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Page(s): 173.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Neck, Shoulder and Low Back Chapters, Traction Section.

Decision rationale: The numbers of visits for the requested treatments are not listed in this case. The records provided do not contain any legible documentation of the patient's treatments especially findings before, during and after the chiropractic, CMT, physical therapy, EMS, US, myofascial therapy or traction. Furthermore, the type of traction required is not listed. Exam findings provided by the orthopedic consultant and PQME detail range of motion, muscle testing, neurological exam and pain intensity. In this case, the documentation provided does

show if any of the requested care was of any benefit. For the most part these records do not exist in the material provided. As for manual therapy and manipulation, Chronic Pain Treatment Guidelines p. 58-60 state that Manual therapy and Manipulation "are recommended for chronic pain if caused by musculoskeletal conditions." It also states that the "goal is to achieve positive symptomatic and/or objective measurable gains in functional improvement." This ODG Low Back Chapter, Traction section states "Not recommended using powered traction devices, but home-based patient controlled gravity traction may be a noninvasive conservative option, if used as an adjunct to a program of evidence-based conservative care to achieve functional restoration. As a sole treatment, traction has not been proved effective for lasting relief in the treatment of low back pain." The ODG Shoulder chapter does not address traction. The ODG Neck Chapter only recommends "home cervical patient controlled traction (using a seated over-the-door device or a supine device, which may be preferred due to greater forces), for patients with radicular symptoms, in conjunction with a home exercise program." Based on lack of records or specific traction being requested I find that the request for traction is not medically necessary.