

Case Number:	CM13-0019587		
Date Assigned:	12/11/2013	Date of Injury:	05/01/2010
Decision Date:	02/03/2014	UR Denial Date:	08/22/2013
Priority:	Standard	Application Received:	09/03/2013

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Physical Medicine and Rehabilitation and is licensed to practice in Oklahoma and Texas. 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.

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 54-year-old male who reported an injury on 05/01/2010. The mechanism of injury was stated to be the patient felt something crawling and slithering near his feet. The patient indicated that in weeks leading up to the incident, the shop was found to have mice and snakes. The patient was noted to be startled and jumped backwards and struck the top of his right shoulder against a shelf. The patient was noted to have tenderness to palpation with muscle guarding and spasm over the paraspinal musculature and trapezius muscles bilaterally upon inspection of the cervical spine. The patient was noted to have tenderness over the lumbosacral joint junction and right sacroiliac joint upon inspection of the lumbar spine and examination of the right shoulder revealed tenderness to palpation over the subacromial region, acromioclavicular joint, and supraspinatus tendon. The patient's diagnoses were noted to include cervical musculoligamentous sprain/strain with bilateral upper extremity radiculitis, right shoulder parascapular strain/tendinitis/impingement, lumbosacral musculoligamentous sprain/strain with bilateral lower extremity radiculitis and sacroiliac joint sprain, and right wrist/flexor tendinitis with carpal tunnel syndrome. The treatment requested was noted to be x-rays, MRI of the cervical spine, cervical traction, an interferential stimulator, and a diagnostic ultrasound for the right shoulder to rule out a rotator cuff.

IMR ISSUES, DECISIONS AND RATIONALES

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

IF unit rental times 2 months: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Transcutaneous Electrotherapy, Transcutaneous Stimulation Page(s):.

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

Decision rationale: The California MTUS Guidelines do not recommend interferential current stimulation as an isolated intervention. However, it is recommended with the treatment of returning to work, exercise, and medications. The clinical documentation submitted for review failed to provide documentation of the above-recommended criteria. There was a lack of documentation indicating the necessity for 2 month rental. Additionally, it failed to provide documentation of exceptional factors to warrant non-adherence to Guideline recommendations. Given the above, the request for IF unit rental times 2 months, QTY: 1.00 is not medically necessary

Electrodes times 8 packs: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Transcutaneous Electrotherapy, Transcutaneous Stimulation Page(s):.

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

Decision rationale: The clinical documentation failed to support the IF unit. Given the above, the request for electrodes times 8 packs is not medically necessary

Batteries times 24: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Transcutaneous Electrotherapy, Transcutaneous Stimulation.

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

Decision rationale: The clinical documentation failed to support the IF unit. Given the above, the request for batteries times 24 is not medically necessary.

Adhesive remover wipes times 32: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Transcutaneous Electrotherapy, Transcutaneous Stimulation Page(s):.

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

Decision rationale: The clinical documentation failed to support the IF unit. Given the above, the request for adhesive remover wipes times 32 is not medically necessary.

Lead wire, QTY: 1.00: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Transcutaneous Electrotherapy, Transcutaneous Stimulation Page(s):.

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

Decision rationale: The clinical documentation failed to support the IF unit. Given the above, the request for lead wire, Qty: 1.00 is not medically necessary

Cervical traction unit, QTY: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 173-174.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 181-183.

Decision rationale: ACOEM Guidelines do not recommend cervical traction as there is moderate research-based evidence that does not support it. The clinical documentation submitted for review failed to provide the necessity for the requested service. The patient's physical examination revealed tenderness to palpation with muscle guarding and spasm over the paraspinal musculature and trapezius muscle bilaterally. The patient was noted to have an axial compression test that elicited radiating pain into the trapezius. The patient's range of motion was noted to be measured by a dual inclinometer, which revealed the patient had flexion of 43 degrees, extension of 51 degrees, right rotation of 71 degrees, left rotation of 68 degrees, right lateral flexion of 36 degrees, and left lateral flexion of 37 degrees. However, there was lack of documentation of exceptional factors to warrant non adherence to Guideline recommendations. Given the above, the request for cervical traction unit, QTY: 1.00 is not medically necessary

Diagnostic ultrasound right shoulder to rule out rotator cuff tear: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Treatment Index, 9th Edition (web), Shoulder, Ultrasound, Diagnostic.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Shoulder Chapter, Ultrasound, online version.

Decision rationale: The Official Disability Guidelines recommend a diagnostic ultrasound as a clinical examination by specialists can rule out the presence of a rotator cuff tear and an MRI or ultrasound could be equally useful for detection of a full thickness rotator cuff tear; however, it was noted an ultrasound may be better up at picking up a partial tear. The clinical documentation submitted for review indicated the patient had an MRI of the shoulder on

08/07/2012, which revealed the patient had no rotator cuff tear. The clinical documentation submitted for review failed to provide the patient had new findings, which would indicate the necessity for an ultrasound for a second study. Given the above and the lack of documentation, the request for diagnostic ultrasound right shoulder to rule out rotator cuff tear, QTY: 1.00 is not medically necessary

Retrospective X-ray for cervical spine, DOS: 6/14/2013: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 182.

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

Decision rationale: ACOEM Guidelines recommend cervical radiographs for patients with acute trauma associated with midline vertebral tenderness, head injury, drug or alcohol intoxication, or neurologic compromise. The clinical documentation submitted for review indicated the patient had sensation to pinprick and light touch in the bilateral upper extremities in the C5-6 dermatomes on the right median nerve distribution. However, the documentation failed to provide the rationale for the requested study as the patient's injury was noted to be 3 years prior and was no longer acute. Given the above, the request for retrospective X-ray for cervical spine, DOS: 6/14/2013, QTY: 1.00 is not medically necessary.

Retrospective X-ray for the lumbar spine DOS: 6/14/2013: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303-305.

Decision rationale: ACOEM Guidelines indicate that lumbar spine x-rays should not be recommended in patients with low back pain in the absence of red flags even if the pain has persisted for 6 weeks. Additionally, it may be appropriate when the physician believes it would aid in pain management. The clinical documentation submitted for review indicated the patient had tenderness to palpation over the lumbosacral joint and right sacroiliac joint. The patient's range of motion was noted to be flexion of 47 degrees, extension of 13 degrees, right side bending of 17 degrees, and left side bending of 16 degrees. However, the clinical documentation failed to indicate the patient had findings indicative of red flags. It failed to include documentation of how the physician would use the x-ray for the patient's care. Given the above and the lack of documentation, the request for retrospective X-ray for the lumbar spine DOS: 6/14/2013, QTY: 1.00 is not medically necessary

MRI of the cervical spine, QTY: 1.00: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 177-178.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Neck & Upper Back Chapter, MRI, Online Version.

Decision rationale: The Official Disability Guidelines recommend repeat MRIs if the patient has a significant change in symptoms and/or findings suggestive of a significant pathology. The clinical documentation submitted for review failed to provide documentation of the above. The patient was noted to have a previous MRI of the cervical spine on 07/26/2012, which revealed the patient had a small 2.5 mm left paracentral to lateral recess extending C6-7 disc protrusion, effacing the thecal sac but not distorting the spinal cord. The clinical documentation submitted for review indicated the patient had sensation to pinprick and light touch in the bilateral upper extremities in the C5-6 dermatomes on the right median nerve distribution. However, it failed to provide a rationale for the requested study and failed to provide this was a significant change and the findings were new. Given the above, the request for an MRI of the cervical spine, QTY: 1.00 is not medically necessary.

Chiropractic manipulation 3 times 4: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 58-60.

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

Decision rationale: CA MTUS states that manual therapy and manipulation is recommended for chronic pain if caused by musculoskeletal conditions. Manual Therapy is widely used in the treatment of musculoskeletal pain. 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 6-8 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 & foot, carpal tunnel syndrome, the forearm, wrist, & hand or the knee. Also, the time to produce effect is indicated as 4 to 6 treatments several studies of manipulation have looked at duration of treatment, and they generally showed measured improvement within the first few weeks or 3-6 visits of chiropractic treatment, although improvement tapered off after the initial sessions. If chiropractic treatment is going to be effective, there should be some outward sign of subjective or objective improvement within the first 6 visits. The clinical documentation submitted for review failed to provide the necessity for 12 sessions of chiropractic care. This request would be excessive. Given the above and lack of documentation, the request for chiropractic manipulation 3 times 4 is not medically necessary.