

<b>Case Number:</b>	CM13-0025034		
<b>Date Assigned:</b>	03/19/2014	<b>Date of Injury:</b>	12/17/2011
<b>Decision Date:</b>	05/19/2014	<b>UR Denial Date:</b>	09/10/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	09/16/2013

### 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 Board Certified in Occupational Medicine 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 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/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:

The patient is a 41 year old female who was injured on 12/17/2011. The mechanism of injury is unknown. Prior treatment history has included a history of surgery to the left shoulder on 09/06/2011. She also received approximately 22-24 sessions of physical therapy in 2013. She has a TENS unit. Diagnostic studies reviewed include MRI of the left shoulder dated 06/25/2013 revealing: 1) Moderate cuff tendinopathy. 2) Focal fraying of the posterior superior labrum. 3) Glenohumeral capsulitis, possibly an adhesive capsulitis. 4) Modest degeneration of the AC joint. An electrodiagnostic study dated 06/18/2013 was a normal study. PR-2 dated 09/09/2013 documented the patient to have complaints of persistent neck pain with MRI showing C5-C6 disc generation. She has completed approximately 22 to 24 sessions of physical therapy in the past. She has access to hot and cold wraps and TENS unit. She uses medications only as needed. Objective findings on exam included tenderness along the cervical paraspinal muscles, trapezius and shoulder girdle on the left as well as rotator cuff and biceps tendon. She has some weakness against resistance to shoulder abduction, flexion, internal and external rotation secondary to pain. Diagnoses: 1. Impingement syndrome status post decompression on the left with persistent symptomatology. 2. Discogenic cervical condition with nerve studies obtained in the past revealing no radiculopathy. The patient has been treated conservatively. Treatment Plan: Avoid overhead reaching, forceful pushing, pulling, lifting, grabbing and heavy lifting. Authorize functional restoration program. Follow up in 4 weeks. She will continue with heat and ice as needed as well as home stretching exercises as tolerated. PR-2 dated 03/15/2013 documented #8 of Behavioral Activation/CBT group therapy for depression for this patient.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**COMPREHENSIVE EVALUATION AND MANAGEMENT PHYSICAL EXAMINATION:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 2 General Approach to Initial Assessment and Documentation Page(s): 3.

**Decision rationale:** According to the CA MTUS guidelines, Physical Examination is guided by the medical history, and the content of focused examinations is determined by the presenting complaint and the area(s) and organ system(s) affected. Examining the musculoskeletal system and elements of other organ systems, particularly those involving tenderness, pain, range of motion, or effort, are subjective to some extent because the patient's response or interpretation is required for findings on the examination. Some patients with musculoskeletal and other complaints will have no objective findings. The medical records document the patient had several medical evaluation encounters where the physical examination was an integral part of the evaluation and management. Therefore the request is not medically necessary in this time and is non-certified.

**X-RAYS OF THE SPINE:** Upheld

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

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

**Decision rationale:** Criteria for ordering imaging studies are: Emergence of a red flag, Physiologic evidence of tissue insult or neurologic dysfunction, Failure to progress in a strengthening program intended to avoid Surgery, or Clarification of the anatomy prior to an invasive procedure. The medical records document a report dated 9/9/2013 that the patient was complaining of persistent neck pain, and MRI showed C5-C6 disc degeneration. On physical examination the patient had tenderness of paraspinal muscles. Electrodiagnostic study report dated 6/18/2103 was normal. In the absence of new documented physiologic evidence of tissue insult or neurologic dysfunction or other red flag, XR rays of the C-spine are not necessary and are non-certified.

**CHIROPRACTIC MANIPULATION OF AN EXTREMITY AT 3 TIMES 4:** 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:** The Chronic Pain Medical Treatment Guidelines state that manipulation is manual therapy is recommended as an option for the low back. Manual therapy is not recommended for the ankle & foot, carpal tunnel syndrome, forearm, wrist & hand and the knee. Chiropractic treatment for the extremities has been requested. Since chiropractic manipulation is not recommended for extremities, the requested service is not medically necessary.

**THERAPEUTIC EXERCISES AT 3 TIMES 4:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Exercise Page(s): 46-47. Decision based on Non-MTUS Citation MTUS: CHRONIC PAIN MEDICAL TREATMENT GUIDELINES, EXERCISE, 46, 47

**Decision rationale:** According to the CA MTUS guidelines, therapeutic exercise is recommended and should be initiated at the start of any treatment or rehabilitation program, unless contraindicated. The medical records document the patient diagnosed with impingement syndrome and discogenic cervical condition. The patient received well over 22 sessions of physical therapy including aqua exercises. However, there is no clear objective functional improvement or pain reduction. The patient continues to have severe pain and is not working. Medical necessity has not been established, and the request is non-certified.

**UNATTENDED ELECTRICAL STIMULATION AT 3 TIMES 4:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Transcutaneous Electrotherapy Page(s): 114-116.

**Decision rationale:** The medical records document the patient has used Transcutaneous Electrical Nerve Stimulation (TENS) for the neck and left shoulder pain. However, there is no documentation of the duration and the frequency of TENS use and no documentation of short and long term treatment outcomes. Objective functional benefit and pain reduction have not been established. Therefore, the request is non-certified.

**TRACTION AT 3 TIMES 4:** Upheld

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

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

**Decision rationale:** According to the CA MTUS Guidelines, traction as a passive physical modality, there is no high- grade scientific evidence to support the effectiveness or ineffectiveness. According to (ODG) Official Disability Guidelines, Home Traction is recommended for patients with radicular symptoms, in conjunction with a home exercise program it would not be advisable to use these modalities beyond 2-3 weeks if signs of objective progress towards functional restoration are not demonstrated. The medical records document the patient has neck pain and is post decompression of left shoulder impingement syndrome. Although there was a documented diagnosis of discogenic condition of cervical spine with radiculopathy, radiculopathy is not corroborated by diagnostic studies. As there is no objective radiculopathy, and the request exceeds the initial recommended duration of 2-3 weeks, the request is not medically necessary and is non-certified.

**MYOFASCIAL RELEASE AT 3 TIMES 4:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 60.

**Decision rationale:** According to the CA MTUS guidelines, Massage Therapy is recommended as an option of treatment in adjunction to other recommended treatment, and it should be limited to 4-6 visits in most cases. Massage is beneficial in attenuating diffuse musculoskeletal symptoms, but beneficial effects were registered only during treatment. According to OGD, it is not advisable to use these modalities beyond 2-3 weeks if signs of objective progress towards functional restoration are not demonstrated. The medical records document the patient had neck pain and left shoulder pain post surgical decompression status. As the records do not document that the patient is actively engaged in active adjunctive treatment, and the number of requested visits exceeds guideline recommendation, the request is non-certified.

**TENS UNIT FOR HOME USE:** Upheld

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

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

**Decision rationale:** The patient used Transcutaneous Electrical Nerve Stimulation (TENS) unit in the past without documentation of objective functional benefit or pain reduction. Medical necessity has not been established, and TENS for home use is non-certified.

**CHIROPRACTIC MANIPULATION OF AN EXTREMITY AT 3 TIMES 4:** Upheld

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

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

**Decision rationale:** According to the CA MTUS guidelines, manual therapy and manipulation is recommended for chronic pain if caused by musculoskeletal conditions. Time to produce effect: 4 to 6 treatments. Extended durations of care beyond what is considered "maximum" may be necessary in cases of re-injury, interrupted continuity of care, exacerbation of symptoms, and in those patients with comorbidities. Such care should be re-evaluated and documented on a monthly basis. Treatment beyond 4-6 visits should be documented with objective improvement in function. The medical records document diagnosed with cervical spine radiculopathy, the patient had several chiropractic sessions in the past that are not documented in the provided records. In the absence of documented the number, the frequency and the duration of chiropractic treatment sessions and whether the patient had any subjective or objective improvement in function from those prior sessions, the request is not medically necessary according to the guidelines. Additional chiropractic manipulation is non-certified.